Certification for Self-Directed Medication Administration
Please Print

OAK HILL SCHOOL

39 Charlton Road, Scotia, NY 12302
518-399-5048 ext. 10 FAX 518-399-6140

School year:________________ Date __________________________

Child's Name____

1. Student correctly identifies own medication by shape, color, etc. ___ Yes ___ No

2. Student correctly states the purpose of the medication (e.g. improve attention). ___ Yes ___ No

3. Student correctly determines correct dosage (e.g. one pill). ___ Yes ___ No

4. Student correctly identifies the time medication is needed during school day (e.g. lunchtime). ___ Yes ___ No

5. Student accurately describes what would happen if medication is not taken (e.g. unable to complete schoolwork). ___ Yes ___ No

6. Student states he/she would refuse medication if there was a concern about its appropriateness. ___ Yes ___ No

Comments: ____

____

Plan: ____

____

Evaluation date__________

Interviewed by ______________________________ ______________________________
Print Name Title

Signature____

5/09