



MEDICAL CERTIFICATE FOR CARRYING OF MEDICATION AND UTENSILS

Patient's name: _____

Date of birth: _____

This is to certify that the above named person carries the following medications and utensils, which are for personal use in the treatment of the medical conditions mentioned.

Medical condition(s): Medication(s) (generic name)
and utensils: _____

Syringes: _____

Needles: _____

Other utensils: _____

Date: _____ Official stamp _____

Physician's signature: _____