WESTERN SCHOOL CORPORATION

PERMISSION FORM FOR PRESCRIBED MEDICATION THAT NEEDS TO BE CARRIED BY THE STUDENT

Date form received by the school:______________ School:________________

Student:_________________________________ Date of birth:___________

Grade:_______________

The following information must be completed in accordance with Indiana Guidelines before a student may carry or self administer medication at school or school events.

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER:

Chronic illness or medical condition of the student:_____________________________

Name and Form of Medication:____

Please check appropriate line:

Tablet_____ Liquid_____ Inhaler_____ Injection_____ Nebulizer_____ Other_____

Medication Instructions (Schedule and dosage): ____
____

Start Date:__________________ Stop Date:______________________

RESTRICTIONS AND/OR IMPORTANT SIDE EFFECTS:____________________________________
____

SPECIAL STORAGE REQUIREMENTS:____
____

This student is both capable and responsible for self-administering this medication and has been instructed in proper usage:

NO________ YES-Supervised__________ YES-Unsupervised__________

The student may carry this medication: NO_________ YES_________

Please indicate if you have provided additional information: ____ **On the back of this form** _____ **As an attachment**

The medical condition stated above requires emergency administration of medication.

________________________________ ________________________
Signature of Physician **Date**

________________________________ ________________________
Printed name of Physician **Phone Number**

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I give my permission for _____________________________ to receive the above medication at school according to standard school policy.

______________________________ ____________________________ ________________
Signature of parent/guardian **Relationship** **Date**

PLEASE NOTE: This must be completed annually. Medication must be kept in original container bearing the original pharmacy label indicating: name, name of medication, dosage, time to be given, doctor's name, and date.

White-Nurse Yellow-Student Pink-Parent

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