NORTH HARRISON COMMUNITY SCHOOL CORPORATION
MEDICATION AUTHORIZATION FORM

Dear Parent or Legal Guardian and Student's Physician,

- This authorization form with clear and specific written directions from the student's physician must be completed, **signed by the physician and parent or legal guardian** and on file in the office of the principal prior to school personnel involvement in the administration of a medication to a student. **A form must be completed for each medication.**
- Only those medications that are necessary to maintain the student in school and are required to be given during school hours shall be administered.
- The medication must be furnished to the principal's office in its original container bearing the original pharmacy label and the student's name; prescription medications must have the original pharmacy label with student's name, dosage and time to be given.
- A revised medication authorization form from the student's physician must be submitted if the original medication authorization is changed.

Student's Name: _____

Medication to be given: _____

Dosage or Amount to be given: _____

Time of Day to be given: _____

Specific Dates to be given: _____

Diagnosis/Indication for medication: _____

PHYSICIAN AUTHORIZATION

I authorize for the above named student to receive this medication during the school day as indicated. Please observe for the following adverse reactions: _____

Physician's Special Instructions:_____

_____

Physician: Please indicate in special instructions if medications (such as inhalers) are to be carried and self-administered by student.

Physician's Signature: _____ **Date:** _____

Physician's Printed Name: _____

Physician's Phone No. _____

Physician's Address/City/State/Zip: _____

PARENT/LEGAL GUARDIAN AUTHORIZATION

I request, authorize, and give permission for the above named student to receive this medication during the school day as indicated. I certify that the above named student has received at least one dose of the medication requested above and has not had adverse reactions to it. I authorize school personnel to exchange information regarding this medication request with the physician listed above and/or with the dispensing pharmacy.

Parent/Legal Guardian Signature: _____ **Date:** _____

THIS AUTHORIZATION IS VALID FOR NO MORE THAN ONE SCHOOL YEAR.
PARENT/LEGAL GUARDIAN MAY WITHDRAW CONSENT (IN WRITING) AT ANY TIME.
This consent form was designed to comply with the provisions of Indiana Code 34-4-16.5-3.5 and amendments thereto, and Rule S-1 of Commission of General Education. 1/01