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 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