Peyton Manning Children's Hospital
St. Vincent

Medication/Treatment Authorization

Student Information

Student's Last Name (Printed)	Student's First Name (Printed)	Student's Date of Birth	School

Medication/Treatment Information

Name of Medication/Treatment (One per form)	Strength (mg, units, etc.)	Start Date	End Date

Dosing Schedule

Time						As Needed (PRN)	Please specify the symptoms for which this medication should be given
Amount							

Special Instructions

Authorization Information

By signing below, I request that a school health professional or designee may administer the medication or treatment to the student named above. I understand students may not transport medication to or from school and I assume responsibility for delivery of this medication to and from the health clinic. All medications must be in their original container. Medications left at school after the end of the school year will be discarded. I will immediately notify the school health professional of any changes to the medication or treatment indicated above. Permission is valid only for the dates specified. Medication will only be administered to the student for whom it is prescribed.

Parent/Guardian Name (Printed)	Parent/Guardian Name (Signature)	Date

Authorization To Carry Medication (Physician Signature Required)

I indicate by signing below that the student named above is a patient under my care who has an acute or chronic or medical condition for which the forenamed medication has been prescribed. The student may possess and self-administer the medication. The student has been instructed in how to self-administer the medication. The nature of the disease or medical condition requires emergency administration of the medication. (IC 20-33-8-13)

Physician Signature	Physician Practice Name	Physician Practice Telephone	Date

Clinic Use Only

Reviewed by	Bin	Medication Retrieval Parent/Guardian Signature	Date

Medication Refill

Date	Qty	Parent/Guardian Signature	Clinic Provider Signature
Date	Qty	Parent/Guardian Signature	Clinic Provider Signature
Date	Qty	Parent/Guardian Signature	Clinic Provider Signature
Date	Qty	Parent/Guardian Signature	Clinic Provider Signature
Date	Qty	Parent/Guardian Signature	Clinic Provider Signature

Medication/Treatment Notes