

Authorization for Self-Carry/Administration of Medication at School

Indiana State law permits a responsible, trained student to carry and /or self administer medication for immediate use in emergency and life threatening situations with written consent from the physician, parent, school nurse, and principal.

Physician /Prescribing Health Care Provider Order

Name of Student _____ DOB _____ School _____

Address _____ Grade _____

Emergency Condition for which the medication is administered _____

Name of medication, dose, and method administered _____

Time or indication for medication _____

Is this a controlled drug? _____ Yes _____ No

Side Effects to be noted / reported _____

The student has been instructed on how to properly administer this medication ____ Yes ____ No

Duration (dates) of administration: From _____ To _____ (limit of one school year)

IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.

Physician Signature Print Signature Phone Date

Parent /Guardian Authorization

I request that my child, named above, be permitted to: ____carry ____ self administer the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original container, labeled with the name of the student, prescribing health care provider and medication; date of original prescription; strength and dose of medication; and directions for use.

Parent Signature Date Student Signature Date

Parent Telephone Numbers

We accept the parent request and physician statement. We will permit and assist the student to be responsible, but reverse the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety factor.

School Nurse Signature Date Principal Signature Date

