

MEDICAL: Written Consent for Administration of Medication Form

Parent/Guardian

In order to protect the health and welfare of the students and school staff alike, Indiana law requires that parents consent, in writing, to the administration of medication. In order for the school nurse, volunteer school nurse, or a staff member to administer medication to your student, the form below must be read and signed.

1. The school must have on record a written order of the prescribing physician/practitioner and written consent of the parent/guardian for prescription medication. There must be a written request from the parent/guardian for Over the Counter (OTC) medications, before they will be administered at school.
2. Medications prescribed and/or OTC meds should be kept in the original container with the pharmacy or brand label affixed. The label must include the following:
 - Student's Name
 - Name of Medication
 - Dosage of Medication
 - Prescribing Physician/Practitioner (if applicable)
3. Medication brought to the school must be checked in at the office by the parent/guardian and kept in a locked cabinet.
4. The school nurse/assigned staff member must be aware of the purpose for which the student is receiving the medication.
5. In specific cases, the school nurse/assigned staff member may require the parent(s)/guardian to come to the school to administer the medication.
6. All prescribed medication will be administered strictly in accordance with the written order of the physician/practitioner. The dosage may be changed only if the school is provided with the written order of the physician/practitioner authorizing the change. The school secretary/staff can not take a physician order over the phone.
7. Over-the-counter medications will not be administered in any manner inconsistent with the instructions on the brand label, unless the school receives a written order of a physician/practitioner authorizing such administration.

I have read and understand the above policy.

Please administer to my student, _____, the prescription/or over the counter medication _____, in accordance with the written order of the physician/practitioner.

Please administer to my student, _____, the over the counter medication(s) as described below:

Medication Information:

1. _____ Dosage _____ Time _____
Name of Medication Mg and # of tabs

Precautions, side effects: _____

2. _____ Dosage _____ Time _____
Name of Medication Mg and # of tabs

Precautions, side effects: _____

3. _____ Dosage _____ Time _____
Name of Medication Mg and # of tabs

Precautions, side effects: _____

Period of Time medication is to be continued: _____

Reason for medication: _____

Parent/Guardian Signature _____ **Date** _____

Please Print Name: _____ **Phone#** _____