PHYSICIAN AUTHORIZATION FORM
FOR ADMINISTRATION OF PRESCRIPTION MEDICATION BY SCHOOL PERSONNEL
(USE BLACK INK)

School personnel may not administer prescription medication brought to school without the physician's written order and the parent/guardian's authorization for a nurse to administer medications or, in her absence, the designated staff to administer medication. Medications must be in pharmacy-prepared containers and labeled with the name of student, name of drug, strength, dosage, frequency, name of physician, and date of original prescription. Ask your pharmacist to prepare two labeled containers, one for school and one for home. THE VERY FIRST DOSE OF THIS MEDICATION FOR CURRENT CONDITION/ILLNESS MAY NOT BE GIVEN AT SCHOOL.

Name of Student _____ Date _____

Address _____ Teacher _____ Date of Birth _____

Condition for which the medication is needed to be administered during school hours _____

_____

Medication (name, strength, dose, and method of administration) _____

_____

Time of administration _____

Medication shall be administered from _____to_____
(Date) (Date)

Relevant side effects to be observed, if any_____

If there are side effects, plan for management_____

_____

(Signature of Physician) _____M.D.

Physician's printed name _____

This form is good for one school year and must be renewed yearly.

……

Authorization by Parent/Guardian for the administration of the above medication by school personnel:

To School Personnel:
I request that the above medication, ordered by the physician for my child _____, be administered by school personnel. I am the parent/guardian of this child and I am acting on my own behalf and on behalf of the minor child. I hereby authorize and agree to hold the Avon Community School Corporation and its officers and employees harmless for the administration of the above medication. I understand that I must supply the school with prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than 45 school day supply. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.
I understand that by operation of law, specifically Indiana Code 34-30-14-2, an Avon Community School Corporation employee or staff member administering medication in accord with the permission statement and the Avon Community School Corporation shall be immune from all liability for acts arising out of the administration of medication in accord with the terms of this document, except in the case of gross negligence or willful and wanton misconduct.
In addition to the immunity described above, in exchange for Avon Community School Corporation's agreement to assume responsibility for the administration of medication as described in this permission statement, we hereby release any and all claims that we may lawfully release at this time for acts or omission arising out of the administration in accord with this grant of permission.
Parent/Guardian Printed Name: _____ Signature: _____

Relationship to Child _____ Date: _____

Daytime Phone: _____ WHEN WAS THE FIRST DOSE OF THIS MEDICATION GIVEN? _____

PARENT REQUEST FORM
FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATION BY SCHOOL PERSONNEL
(USE BLACK INK)

Only those medications that are medically necessary during school hours for a student's attendance or written in an IEP should be sent to school. Persons who may assist your child with medications include the school nurse (RN) and trained school staff. The parent/guardian must give a written request. The medication must be in the original container and properly labeled with student's first and last name. This form is good for one school year and must be renewed yearly.

THE VERY FIRST DOSE OF THIS MEDICATION FOR CURRENT CONDITION/ILLNESS MAY NOT BE GIVEN AT SCHOOL.

NOTE: A physician authorization form must accompany all prescription medication brought to school.

OVER-THE-COUNTER MEDICATIONS NEEDED LONGER THAN TWO WEEKS MUST HAVE REVIEW AND APPROVAL OF THE SCHOOL NURSE AND MAY REQUIRE A PHYSICIAN'S ORDER.

I am the parent/guardian of the child named below and I am acting on my own behalf and on behalf of this minor child. We hereby authorize and agree to hold the Avon Community School Corporation and its officers and employees harmless for the administration of the following medication.

NAME OF STUDENT: _____ DATE OF BIRTH: _____
(Hand written on a non-prescription container.)

TEACHER: _____ GRADE: _____

NAME OF MEDICATION & STRENGTH: _____

DOSAGE (amount): _____

TIME TO BE GIVEN AT SCHOOL: _____

REASON OR HEALTH PROBLEM: _____

MEDICATION TO BE GIVEN FROM: _____ TO : _____
(Date) (Date)

HOW IT IS TAKEN: _____
(Example: by mouth, by inhaler, with food or after meals)

WHEN WAS THE FIRST DOSE OF THIS MEDICATION GIVEN? _____

I understand that by operation of law, specifically Indiana Code 34-30-14-2, an Avon Community School Corporation employee or staff member administering medication in accord with the permission statement and the Avon Community School Corporation shall be immune from all liability for acts arising out of the administration of medication in accord with the terms of this document, except in the case of gross negligence or willful and wanton misconduct.

In addition to the immunity described above, in exchange for Avon Community School Corporation's agreement to assume responsibility for the administration of medication as described in this permission statement, we hereby release any and all claims that we may lawfully release at this time for acts or omission arising out of the administration in accord with this grant of permission.

_____ _____ _____
PARENT'S/GUARDIAN'S SIGNATURE DAYTIME PHONE DATE

Reviewed by RN: _____ Staff ____may/_____may not administer
(Date)

_____ _____
RN (Print Name) RN SIGNATURE

AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICINE AT SCHOOL AND AFTER-SCHOOL ACTIVITIES

Board of Education policy permits a responsible, trained student to carry and/or self –administer medication for asthma, severe allergic (anaphylactic) reaction, or diabetes on his/her person for immediate use in a life-threatening situation with written order of physician, parent request, school nurse and principal approvals.

PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER ORDER

Name of Student _____ Date of Birth _____

Address _____ Grade _____

Condition for which the medication is administered _____

Name of medication, dose and method administered _____

Time or indication for administration _____

Is this a controlled drug? _____ Yes _____ No

Side effects to be noted/reported _____

Other recommendations _____

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 Name	Telephone	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 pharmacy container, labeled with name of student, prescribing health care provider, and medication name, date of original prescription, strength and dose of medication, and directions for use. I will also provide extra medication with a Physician Authorization Form to be kept in the school clinic for emergencies. No more than a 45 school day supply of medication will be kept at school.

I am the parent/guardian of the child named above and I am acting on my own behalf and on behalf of this minor child. We hereby authorize and agree to hold the Avon Community School Corporation and its officers and employees harmless for the administration of this medication.

I understand that by operation of law, specifically Indiana Code 34-30-14-2, an Avon Community School Corporation employee or staff member administering medication in accord with the permission statement and the Avon Community School Corporation shall be immune from all liability for acts arising out of the administration of medication in accord with the terms of this document, except in the case of gross negligence or willful and wanton misconduct.

In addition to the immunity described above, in exchange for Avon Community School Corporation's agreement to assume responsibility for the administration of medication as described in this permission statement, we hereby release any and all claims that we may lawfully release at this time for acts or omission arising out of the administration in accord with this grant of permission.

_____	_____	_____	_____
Parent Signature	Date	Student Signature	Date

_____

Parent Phone Numbers

We accept the parent request and physician statement. We will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. We will contact the parent as soon as possible in this event.

_____	_____	_____	_____
School Nurse Signature	Date	Principal Signature	Date