

# 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					
<p>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.</p>					
Parent/Guardian Name (Printed)		Parent/Guardian Name (Signature)		Date	
Authorization To Carry Medication (Physician Signature Required)					
<p>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]</p>					
Physician Signature		Physician Practice Name		Physician Practice Telephone	Date
Clinic Use Only					
Review	Bin	Medication Retrieval Parent/Guardian Signature		Date	
Medication/Treatment Notes					