SOUTHWEST SCHOOL CORPORATION

Health Services

Authorization for Administration of Medication at School

Student's Name: _____ Grade _____ Room _____

Date medication to begin: _____ **Date medication is to be discontinued:** _____ ***Medication expiration date:*** _____

Medication/Strength	Dose	Time
		AM / PM / PRN (as needed)

How Taken ☐By mouth ☐Inhaled ☐Patch Other_____ Medical Condition_____

Other medications taken at home _____

***** Note: It is the responsibility of the parent/legal guardian to cut tablets of medication (if necessary) before sending to school. The school will dispose of any medication left after the close of this school year.***

Instruction for School Delays (scheduled and unscheduled)

☐My child will take his/her medication at the regularly scheduled time as indicated above.

☐**OR** Special arrangements need to be followed, which include_____

- ☐ I assume the responsibility for the safe transport of this medication to school.
- ☐ I request the medication (prescription medication only) be given on field trips, as prescribed.
- ☐ I will notify the school by way of physician's order of any prescription medication changes (ex: dosage change, medication is discontinued, etc.)
- ☐ I give permission for the school nurse to communicate with the student's teacher, physician and necessary school staff about my child's health condition and the action of the medicine.
- ☐ I give permission for the medication to be given by the designated personnel (the school nurse may not always be present in the school).

Daily Medications: I understand that is my responsibility to keep my child's daily medication paperwork up-to-date and to maintain an adequate supply of daily medications at school. I understand that failure to do so may result in the School Nurse discontinuing the medication.

☐ **I certify that I have read and understand the information within this authorization and information contained in SWSC Medication Administration Guidelines.**

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_____ _____ _____

Signature Parent/ Legal Guardian Daytime Telephone Date

MEDICATION RETURN INFORMATION: This is to certify that I picked up my child's medication. Number of Doses: _____

Parent/Guardian Signature_____ Date _____

Please contact Susan Tincher, District Nurse, with any questions concerning medications at school (812-268-3341, extension 2765