# METROPOLITAN SCHOOL DISTRICT OF WASHINGTON TOWNSHIP

8550 Woodfield Crossing Boulevard, Indianapolis, IN 46240 (317) 845-9400

**5330 F/B**
**Blue**

## AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

**Parent/Guardian:** A prescribing physician must provide a written order stating the name of the student, the amount of medication to be administered, identification of the medication, directions for proper administration of medication, and the signature of the physician or practitioner. THE FOLLOWING INFORMATION IS THEREFORE NECESSARY FOR ANY STUDENT TO RECEIVE PRESCRIBED MEDICATION/ TREATMENT IN SCHOOL. **ALL SPACES MUST BE COMPLETED.**

_____ _____

Name of Student Address

_____ _____

School Grade Date of Birth

A. I am requesting that an authorized representative of the MSD Washington Township administer the following prescribed medication or treatment. (Prescription medication in the original container required. A copy of the prescription label may be attached or the nurse may write the information from the prescription label below.)

Prescription Medication: _____

Dosage/Frequency/Prescription Number: _____

Directions for Administration/Side Effects _____

_____

Medication Administration Beginning Date: _____ End Date: _____

****Building Nurse will complete this section upon receipt of prescription label on medication.****

Pharmacy Name: _____

Pharmacy Telephone Number: _____

Verified Medication, Dosage, and Frequency: _____

Physician/Practitioner Name: _____

B. For all students grades K-8 and preschool, I will assume responsibility for safe delivery to the school health clinic at the beginning of the school year and *retrieval from school at the end of the school year.* **Preschool and students grades K-8 MAY NOT transport medication(s) to and from school.** *Medications left at school following the close of the school year will be destroyed.*

C. **North Central students may transport medication(s) to and from school if this form (5330 F/B) is on file and signed by the parent/guardian.** *Medications left at school following the close of the school year will be destroyed.*

D. I will notify the school in writing if there is any change in the use of the medication(s)/treatment:

X_____ _____

Signature of Parent/Guardian Date

_____ (H)_____(W)_____

Printed Name of Parent/Guardian Telephone Numbers

**PERMISSION IS VALID ONLY FOR THE CURRENT SCHOOL YEAR AND ONLY FOR THE STUDENT LISTED ON THE FORM. STUDENTS ARE NOT PERMITTED TO SHARE THEIR MEDICATION WITH OTHER STUDENTS. VIOLATIONS WILL RESULT IN DISCIPLINARY ACTION.**