METROPOLITAN SCHOOL DISTRICT OF WASHINGTON TOWNSHIP

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

5330 F/G
Green

AUTHORIZATION FOR PRESCRIBED SELF ADMINISTRATION AND/OR POSSESSION OF MEDICATION

Parent/Guardian: THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO SELF-ADMINISTER AND/OR CARRY PRESCRIBED MEDICATION(S) IN SCHOOL. **ALL SPACES MUST BE COMPLETED.**

Name of Student _____ Address _____

School _____ Grade _____ Date of Birth _____

A. Only a student with a chronic disease or medical condition may possess and self-administer and/or carry medication for the chronic disease or medical condition during school hours. The medication must be kept in the identified prescription container issued from the pharmacy. No other substance other than the prescribed medication may be carried in the prescription container. The following conditions must be met:

1. **The student's parent/guardian must file authorization for the student to possess and self-administer the medication.**
I hereby request for my child to self-administer the following prescribed medication(s). I understand that I may withdraw my consent at any time by submitting a written request to the building principal. Furthermore, I understand this consent is valid for only the current school year. I will notify the school immediately if there is any change in the use of the medication(s).

During school hours, this student has permission to: (Healthcare provider selects one)

- ☐ Carry medication only to be administered by trained personnel
- ☐ Carry medication and self-administer with supervision
- ☐ Carry medication and self-administer without supervision

X_____
Physician/Practitioner Initials

X_____ _____
Signature of Parent Date

_____ _____
Home Telephone Work Telephone

2. **A healthcare provider states in writing that the student has an acute or chronic disease or medical condition for which he/she has prescribed medication. The nature of the disease or medical condition requires emergency administration of the medication:**
I, _____, state that the above named student has a chronic disease or medical condition, which requires
(Physician/Practitioner Name)
administration of the below listed medication.

Prescription Medication: _____

Dosage/Frequency: _____

Directions for Administration/Side Effects _____

_____

Medication Administration Beginning Date: _____ End Date: _____

3. **A healthcare provider states in writing that the student has been instructed on how to self-administer the medication.**
I, _____, state that the above named student has been instructed in how to self-administer the above listed
(Physician/Practitioner Name)
medication.

Physician/Practitioner: X _____
(Signature of Physician/Practitioner)

Physician/Practitioner: X _____
(Printed name of Physician/Practitioner)

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.