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? _____