SELF ADMINISTER MEDICATIONS AT SCHOOL: PARENT INSTRUCTION GUIDE

IMPORTANT MEDICATION INFORMATION

All medications must have an MVCSC self-administer medication permission form (back of this guide) completed and on file.

Students are not permitted to carry or possess any medication without a physician's statement in writing.

Medication for Chronic Disease or Medical Condition

A student with a chronic disease or medical condition may possess and self-administer medication for the chronic disease or medical condition if the following conditions are met:

1. the student's parent has filed an authorization with the schools health service office for the student to possess and self- administer the medication. The authorization must include the following doctor's statement:
2. a physician states in writing that:

   (a) the student has an acute or chronic disease or medical condition for which the physician has prescribed medication;
   (b) the student has been instructed in how to self-administer the medication; and
   (c) the nature of the disease or medical condition requires emergency administration of the medication.

The Self Administer Medication Permission Form must be signed by a physician and filed with the student's Health Services or designee **annually**.

Additional information can be found in the MVCSC Health Services Handbook located on the Health Services home page at https://www.mvcsc.k12.in.us/Administration/healthservices.

Please call the nurse at your school if you have any questions.

Mt. Vernon Community School Corporation

Self Administer Medication Permission Form

Student's Name_____ Grade_____ DOB_____

Parent/Guardian Name_____ Phone_____

School_____ Start Date _____ End Date _____

Name of Medication_____ Purpose of Medication_____

Mt. Vernon Community School Corporation is bound by Indiana state law to follow certain regulations regarding medication for a chronic disease or medical condition. A student may possess and self-administer medication for a chronic disease or medical condition only if the parent/guardian annually files, with the school, the signed Authorization and Physician's Statement below.

Parent/Guardian Authorization

I am the Parent/Guardian (circle one) of the student identified below. I authorize Mt. Vernon Community School Corporation to permit this student to possess and self-administer the medication identified below on school property and/or school functions.

_____

Parent/Guardian signature Date

Physician's Statement

I am a licensed physician. I provide medical services to _____and have prescribed
(Name of student)

_____for this patient. I certify that the following statements are true and accurate:
(Name of medication prescribed)

1. An acute or chronic disease or medical condition exists for whom the above named medication is prescribed.
2. The student named above has been given instructions as to how to self-administer the medication.
3. The nature of the disease or medical condition requires **emergency** administration of the medication.

_____

Physician's Signature Date

Address: _____

_____

Physician's Printed Name Phone _____

_____

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