

Indiana State Law: Possession and Self- Administration of Medication

IC 20-33-8-13 Possession and self-administration of medication permitted

Sec. 13. (a) Discipline rules adopted under section 12 of this chapter must provide that a student with a chronic disease or medical condition may possess and self-administer medication for the chronic disease or medical condition during the times and in the places set forth under section 14(b) of this chapter if the following conditions are met:

(1) The student's parent has filed an authorization with the student's principal for the student to possess and self-administer the medication. The authorization must include the statement described in subdivision (2).

(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.

(b) The authorization and statement described in subsection (a) must be filed annually with the student's principal.

IC 20-33-8-14 Grounds for suspension or expulsion

Sec. 14. (a) The following are the grounds for student suspension or expulsion, subject to the procedural requirements of this chapter and as stated by school corporation rules:

(1) Student misconduct.

(2) Substantial disobedience.

(b) The grounds for suspension or expulsion listed in subsection (a) apply when a student is:

(1) on school grounds immediately before or during school hours, or immediately after school hours, or at any other time when the school is being used by a school group;

(2) off school grounds at a school activity, function, or event; or

(3) traveling to or from school or a school activity, function, or event.

Griffith Public Schools

Physician Authorization for Possession and Use of Emergency Medication

Student Name: _____ **DOB:** _____

The student listed above has been diagnosed with a chronic disease that may require emergency medication to be administered while at school or during school sponsored activities.

Chronic Disease: _____

Medication: _____

Dosage Instructions: _____

Authorization for the student named above to:

_____ Keep emergency medication in his/her possession

_____ Self- administer the prescribed medication as allowed by law

Adverse reactions that should be reported to the prescriber:

Procedure to follow in the event that medication does not produce the expected results from condition requiring emergency medication:

Adverse reaction for unauthorized user:

As the health care provider of the above named, I have instructed this patient how to use this medication and is capable of using the medication as instructed safely and appropriately. I believe that this patient should carry this medication and will use it in a responsible manner, following my orders and instructions.

Physician and parent/guardian names, signatures, and emergency phone numbers are required.

Physician Name: _____ Phone: _____

Physician Signature: _____ Date: _____

Parent Name: _____ Phone: _____

Work: _____ Other: _____

Parent Signature: _____ Date: _____

A copy will be provided to Principal and to School Nurse

Griffith Public Schools

Medication Self Carry Contract

School: _____ Grade: _____ Date: _____

STUDENT: _____ **DOB:** _____

- I plan to keep my rescue inhaler with me at school rather than in the school health office.
- I agree to use my rescue inhaler in a responsible manner, following my physician's orders.
- I will notify the school health office if I am having more difficulty than usual with my asthma.
- I will not allow any other person to use my inhaler.

Student's Signature: _____ **Date:** _____

PARENT/GUARDIAN: _____

This contract is in effect for the current school year unless revoked by the physician or the student does not meet the above safety contingencies.

- I agree to see that my child carries his/her medication as prescribed, that the device holds medication, and the date is current.
- The school nurse recommends a back-up medication for storage in the health office for emergencies.
- I will review the health status with the student and update the school nurse regularly, as agreed in the health care plan.
- I will supply the school a Health Care Provider signed medication authorization for this medication.

Parent's Signature: _____ **Date:** _____

NURSE: _____ **SCHOOL:** _____

- The above student has demonstrated correct technique for medication use, understand the physician order for time and dosages, and understand the signs and symptoms associated with need for emergency medication use.
- School staff with the need to know about the student's condition and possession of medication will receive notification.
- I will review the medication authorization provided by the parent and signed by the health care provider.

Nurse's Signature: _____ **Date:** _____