Southwest Dubois County School Corporation
Authorization for Medication or Treatment

Student_____**Date of Birth**_____

Current Grade_____ **Gender** ▫ **M** ▫ **F** **School**_____

Parent/Guardians Name_____ **Telephone** _____

Address_____**City**_____ **Zip** _____

Physician's Authorization for Medication

This student requires the administration of a prescription medication during school hours. This medication should be administered as follows

Physician Name_____ **Physician's Phone Number**_____

	Medication Name/Treatment	Dosage	Time to be given	Stop Date
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

_____ _____

Physician's Signature **Date**

Has been instructed on self-administering emergency medication and may carry on person _____

Physician's Initials & Date

Parent Authorization for prescription medication or treatment and release of information

We ask you to note the following Indiana Statute: Indiana Code 34-4-16.5-5-3.5. A school administrator, teacher, nurse, or other school employee designated by the school administrator, who in good faith administers medication to a pupil in the presence of another adults, with the written permission of the pupil's parents or guardians, and in compliance with the written instructions of the physician, which shall be on file with the school, is not liable for civil damages as a result of the administration, except for an act or omission amounting to gross negligence or willful wanton misconduct.

1. I am requesting permission for my child, named above, to: (check all that apply)
   - ____ receive prescribed medication
   - ____ receive prescribed treatment
   - ____ self-administer prescribed inhaler (in the presence of authorized staff member/or to inform authorized staff member immediately after use.)

   In accordance with Physician's prescription
2. I will assume responsibility for safe delivery of medication to school
3. I will notify the school immediately if there is any change in the use of medication or the prescribed treatment
4. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.
5. I grant permission to release and exchange information, medical records, and speak to the nurse/doctor regarding the above named student.
6. I have been informed that the Family Education Rights and Privacy Act (FERPA) of 1974 requires that I have access to and may review any or all of my child's school records and I may challenge the content of the records. This release expires one year from the date of my signature, unless I revoke my consent in writing to the Southwest Dubois County School Corporation.

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Parent/Guardian Signature **Date**