



South Adams Schools

1012 Starfire Way

Berne, IN 46711

FAX: 260.589.2112

Dear Parent/Guardian:

In order to protect the health and safety of children, Indiana rules and regulations require that schools observe certain safeguards when administering medication to students during the school day. Our school district requires that the following forms must be on file before we begin to give any medicine at school:

1. Signed consent by the parent or guardian permitting the student to receive medicine at school. Please complete the attached consent form and return to the school nurse.
2. Signed medication order. The prescribing physician must provide a written order form stating the dosage of medication, the hours for administration, and the period of time the medication is to continue. This order must be provided to the school nurse at the beginning of each academic year and renewed as needed.
3. Medicines should be delivered to the school in a pharmacy labeled container by you or a responsible adult whom you designate. Please ask your pharmacy to provide separate bottles for school and home.

When your child needs medicine to be given during the school day, please act quickly to follow these policies so that we may begin to give the medicine as soon as possible. Remember, we cannot give prescription medication until a signed form is on file. Thank you for your help. Please call or email us with any questions or concerns.

Sincerely yours,

Haley Provost, RN, BSN/Sydney Isch RN, BSN

South Adams PK-12 School Nurses

Phone: (260) 589-1109

Email: hprovost@southadams.k12.in.us

PERMISSION FORM FOR PRESCRIBED MEDICATION/TREATMENT

Child's Name _____ Gender _____ Birth Date _____

I request that my child be assisted in taking the medication/treatment listed below at school by authorized school personnel or permitted to medicate/treat herself/himself as authorized by me and the physician (see below).

In order to provide the best care for my child, the school nurse also has my consent to share the information below with appropriate school personnel. Yes _____ No _____

Date _____ Parent/Guardian Signature _____

THE FOLLOWING IS TO BE COMPLETED AND SIGNED BY THE PHYSICIAN:

Diagnosis for which medication/treatment is ordered _____

Name of medication/treatment _____

Dose to be given _____ Time to be administered _____

Form of medication/treatment: Tablet/capsule _____ Liquid _____ Inhaler _____

Nebulizer _____ Other (specify) _____

Date to start medication/treatment _____

Date to stop medication/treatment _____

For episodic/emergency use only? Yes _____ No _____

Restrictions and/or side effects (please describe) _____

This student is both capable and responsible for self-administering this medication/treatment:

Yes, supervised _____ Yes, unsupervised _____ No _____

If medication is an inhaler or Epi Pen, this student may carry the medication:

Yes _____ No _____

Additional comments _____

Date _____ Physician's Signature _____

Address _____ Phone _____