SUNMAN-DEARBORN COMMUNITY SCHOOLS

East Central HS: Fax# 812-576-4811 **Bright Elementary: Fax# 812-637-4606**
S-D Middle School: Fax# 812-576-3506 **Sunman Elementary: Fax # 812-623-4330**
North Dearborn Elementary: Fax# 812-576-1901

PHYSICIAN'S PERMISSION FOR PRESCRIBED MEDICATION

Date form received by school _____

STUDENT _____ **Date of birth** _____
Last First M.I.

******TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER******

NAME OF MEDICATION _____

Reason for medication _____

FORM OF MEDICATION: ___tablet/capsule ___liquid ____ inhaler ___injection/epipen ___nebulizer

**Instructions: Time to be given at school _____

Dose _____

Start date: _____ Stop date:_____

RESTRICTIONS and/or side effects: _____

Is this student both capable and responsible for self-administering this inhaler/epipen/insulin (if applicable)?

At School? _____ NO ____YES, with supervision _____YES, without supervision

On School Bus? _____ NO ____YES (unsupervised ONLY)

PHYSICIAN'S SIGNATURE _____ **Date** _____

I give permission to school personnel to administer the above medication as instructed and agree to deliver the medication to the school **in the original container with the label intact. I understand that it is the student's responsibility to report on time for this medication.
**I will notify the school immediately of any changes of: dose, time, physician or discontinuation of this medication.
**I give permission to school personnel to speak to the prescribing physician/healthcare provider if the dose exceeds the standard according to the Physicians Desk Reference (PDR), if needed. The call is to verify what is written for the protection of your child.
**I agree to absolve Sunman-Dearborn Corporation and their employees from any events arising from the administration of this medication.

PARENT/GUARDIAN SIGNATURE _____ **Date**_____