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

PARENT PERMISSION FOR ADMINISTRATION OF STUDENT MEDICATION UNTIL PHYSICIAN WRITTEN ORDERS ARE OBTAINED

Grade/Teacher _____

Name of Student _____ Birthdate _____

Name of medication _____ Tablet--capsule--liquid--inhaler, injection, nebulizer

Reason for medication _____

Instructions (as stated on RX label) _____

RX# _____

SCHOOL TIME _____ and amount to be given at school _____

Start date _____ Stop date _____

Restrictions and/or important side effects, if any _____

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 original prescription 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 in dose, time, physician or discontinuation of the above medication.

I give permission to school personnel to speak to the prescribing physician/healthcare provider if the dose exceeds the standard according to the Physician 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 School Corporation and it's employees from any events arising from the administration of this medication.

Parent/Guardian Signature _____ **Date** _____

Telephone during school hours ( ) _____ Other telephone ( ) _____