

# 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 its employees from any events arising from the administration of this medication.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Telephone during school hours ( ) \_\_\_\_\_ Other telephone ( ) \_\_\_\_\_