HUNTINGTON COUNTY COMMUNITY SCHOOL CORPORATION

MEDICATION CONSENT FORM

The clinic staff does not administer any medications, including ibuprofen, Tylenol, cough drops etc. except with specific directions from the parents. If medication must be taken during school hours, the following is needed:

1. Written consent forms are required each school year.
2. Prescription medication/over-the-counter medication must be in the pharmacy labeled/original container with the student's legal name, time to be taken, amount to be taken and the name of the drug. (Over-the-counter medication should also be in an original container.)
3. Students are required to provide their own medication.
4. **IC 20-8.1-5.1-7.5,** requires that written parental permission and physician authorization statement be on file with school administration for any **student needing to possess and self-administer medication such as inhalers for asthma or Epi-pens for allergic reactions.**
   The physician statement **<u>must be filed annually</u>** and must state in writing that:

a. the student has an acute or chronic disease or medical condition for which the physician has prescribed medication;
b. the student has been instructed in how to self-administer the medication; and
c. the nature of the disease or medical condition requires emergency administration of the medication.

This signed consent form will be valid for the current school year only. A new consent form is required for any changes to the information below, such as type of medication, dosage or time to be given.

PERMISSION FOR MEDICATION

Name of Student: ______________________________ Grade: ______________
Name of medication: ______________________________
Amount of medication: ______________________________
Time to be given: ______________________________
Purpose of medication: ______________________________

I hereby give my permission for my student to take the above medication at school and that **my signature acts as a release to exchange information with the doctor about this medication and the health issue for which the medication is prescribed**. The school nurse or clinic assistant, or in their absence, his/her designee may administer the medication. **A parent or individual 18 years of age or older with written permission from the parent may bring the medication to school and pick up unused medication at the end of the school year.**

Date	**Signature of Parent**	Home Phone/Work Phone

PHYSICIAN AUTHORIZATION STATEMENT

I verify that this student has an acute or chronic disease or medical condition and has been instructed how to self-administer the medication and that the nature of the disease/condition may require emergency administration of this medication.

Date	**Signature of Physician**

Copy of medication policy is available upon request. Revised 7/20