East Central High School
1 TROJAN PLACE
ST. LEON, INDIANA 47012
PHONE: 812-576-4811
FAX: 812-576-2047

PARENT PERMISSION FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATION OR UNTIL PHYSICIAN'S WRITTEN ORDER FOR MEDICATION IS OBTAINED

Teacher/Grade_____

Name of Student_____ Date of Birth _____

Name of
Medication_____tablet/capsule/liquid/inhaler/injection/nebulizer
(circle type of medication)

Reason for Medication_____

Dose:_____

Instructions (time and dose to be given at school, if RX, stated on bottle)_____

_____

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 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 Physicians Desk Reference (PDR). The call is to verify what is written for the protection of your child. I agree to absolve Sunman Dearborn School Corporation and employees from any events arising from the administration of this medication.

Parent/Guardian
Signature_____Date_____

Telephone during school hours ( )_____ Other telephone_____