SUNMAN DEARBORN COMMUNITY SCHOOLS

ECHS	FAX: 812/576-2047	BES	FAX: 812/637-4606
ECMS	FAX: 812/576-3506	NDES	FAX: 812/576-1901
		SES	FAX: 812/623-4330

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 (E.S.T.)_____

Dose_____

Start: _____date form received or other date (specify)_____

Stop: _____end of school year or other date/duration_____

RESTRICTIONS and/or important side effects_____

Storage requirements_____

Is this student both capable and responsible for self-administering this inhaler/epipen:

At School? ____ No ____ Yes, with supervision ____ Yes, without supervision

While transporting on a 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 in dose, time, physician or discontinuation of the above medication.

I give permission to school personnel to speak to the prescribing physician/health care provider if he 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 employees from any events arising from the administration of this medication.

Parent/Guardian Signature_____Date_____

Revised 6/2021