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

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

Teacher/Grade_____

Name of Student_____ Date of Birth_____

Last First M.I.

Name of Medication_____ tablet/capsule/liquid, inhaler, injection, nebulizer

Reason for Medication_____

Instructions (as stated on RX label)_____

RX# _____

SCHOOL TIME (E.S.T.)_____ 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 education as instructed and agree to deliver the medication to the school in the original container with the 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/health care 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 employees from any events arising from the administration of this medication.

Parent/Guardian Signature_____ Date_____

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

Revised 6/2021