MEDICATION PERMIT

Randolph Southern School Corporation

Health Care Providers: Please mail this Authorization to the **School Nurse** at:

☐ Randolph Southern School, 3 Rebel Drive, Lynn, IN 47355 or send to secure FAX @ (765) 874-2717

Student's Name _____ Birth Date: _____

Grade _____ Homeroom Teacher _____

List any drug allergies / adverse reactions: _____

PARENT OR LEGAL GUARDIAN AUTHORIZATION (for all medications)

If a medication must be given during school hours, this form must be completed. The parent/guardian must provide the school with the FDA approved over-the-counter or prescription medication in its original container with unexpired date which will be given as directed on the container or as directed by the below physician. It is the responsibility of the parent/guardian to notify school personnel of medication changes and to complete a new Authorization.

Name of Medication _____ Dosage _____ Time of Day to be Given_____ a.m. / p.m. OR as needed beginning (date to start) _____ to (date to end) _____ (not to exceed current school year)

Medications must be delivered to the school nurse, principal and/or the school designee according to Indiana Senate Bill No. 376 (effective July 1, 2001). Medications must be delivered in their original container and properly labeled with the student's name, name of medication, unexpired date, and instructions re: dosage, time/frequency of administration.

My permission is hereby granted to the Randolph Southern School Corporation staff to assist my child in the administration of the named medication in accordance with Randolph Southern School Corporation's medication policy. I hereby release and discharge the Randolph Southern School Corporation and staff from any liability whatsoever that might result from administering or not administering medication.

I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance at the Randolph Southern Schools. This authorization expires as of the last day of school for the 2021 – 2022 school year.

Date _____ Parent/Legal Guardian Signature _____ Home/Cell #_____ Work #_____

PHYSICIAN / DENTIST AUTHORIZATION (for PRESCRIPTION MEDICATIONS ONLY)

Student Name: _____ Condition/Illness Requiring Medication: _____

Medication: _____ Dosage: _____ Route: _____

Frequency/Time to be given: _____

Start Medication on _____ Stop Medication on _____

Common Side Effects of Medication: _____

Student may carry and self-administer medication due to a life-threatening condition: ☐ Yes ☐ No

Special Instructions: _____

Physician / Dentist Signature: _____Date: _____Address: _____

Telephone Number: _____ FAX Number: _____

PLEASE NOTE: If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.

STUDENT MEDICATION PROCEDURES

* All medication shall be administered in accordance with Indiana State Statute.

* Written authorization/instructions by parent or legal guardian must accompany every medication that is to given during school hours. Authorization forms are available in the school office. Authorization must include:

Name of student to be taking the medication
Name of medication
Dosage (amount to be given)
Time/Frequency (hour @ which medication is to be given)
Length of time which medication is to be given

* A written order by a physician as well as written parent authorization must be provided for all prescription medication. The physician's instructions must include:

Name of student to be taking the medication
Name of medication
Dosage (amount to be given)
Route of administration
Time/Frequency (hour @ which medication is to be given)
Duration of administration

* Whenever a change in medication, dosage, and/or frequency occurs, parent/physician authorization must accompany the new medication.

* Students with a chronic disease / medical condition may possess and self-administer medication if the following conditions are met:

1) The student's parent/guardian annually files authorization with the student's principal for the student to possess and self-administer the medication
   AND
2) A physician annually states in writing that the student has a disease or medical condition for which the physician has prescribed medication, the student has been instructed in how to self-administer the medication, and the nature of the disease / medical condition requires emergency administration of the medication.

***** Medication that is possessed by a school for administration during school hours or at school functions may be released to the student's parent or to an individual who is eighteen(18) years of age or older and who has been designated, in writing, by the student's parent to receive the medication.

*****A school may send home medication that is possessed by a school for administration during school hours or at school functions with a student only if the student's parent provides written permission for the student to receive the medication.

* All medications (prescription and nonprescription) will be kept in an appointed, secure area in the nurse's office.

* All medication must be brought to school and kept in the original container.
Nonprescription medication must be brought in the purchased container and labeled with the student's name and unexpired date.

Prescription medication must be brought in its original container bearing the pharmacy label, student's name, unexpired date and written instructions of a physician.

* School personnel will maintain a record of all medications administered during school hours.

* School personnel will inform parent/guardians of any circumstances resulting in medications not being given during school hours.

School Release of Medication

I give _____ **(who is at least 18 years of age) permission to receive**

_____ **(Name of Medication)**

_____ **(Name of Medication)**

Parent / Guardian Signature: _____ Date_____