MEDICATION PERMIT

Northeastern Wayne Schools

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

☐ Northeastern Elementary School 534 W. Wallace Road, Fountain City, IN 47371 or send to secure FAX @ (765) 847-5470

☐ Northeastern Junior-Senior High School 7295 U.S. 27 North, Fountain City, Indiana 47371 or send to secure FAX @ (765) 847-2875

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 Northeastern Wayne School staff to assist my child in the administration of the named medication in accordance with Northeastern Wayne School's medication policy. I hereby release and discharge the Northeastern Wayne School 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 in the Northeastern Wayne Schools. This authorization expires as of the last day of the current school year.

Date ________ Parent/Legal Guardian Signature ______________________________

Home phone ________ Work phone ________ Cell phone ________

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.