Nettle Creek School Corporation
PARENTAL AUTHORIZATION TO ADMINISTER MEDICINE
2022-2023 SCHOOL YEAR

ALL MEDICATIONS MUST BE DELIVERED TO SCHOOL BY AN ADULT. STUDENTS ARE NOT TO TRANSPORT AND/OR CARRY ANY MEDICATIONS TO/FROM SCHOOL (UNLESS OVER 18) OR DURING THE SCHOOL DAY.

The following information is necessary for any student to use medications or to receive treatment in school.
All spaces must be completed.

Name of Student _____ Grade _____

I am the parent, with legal custody, or the legal guardian of the above named student. I am requesting permission for my child to take medication at intervals during the school day. I hereby give my consent and authorize the school nurse or other designated school employee to:

I. Administer _____, an **over-the-counter medication,** which **I am hereby supplying the school**, in accordance with the written instructions on the label. Medications must come in the original bottle. ONLY THE MANUFACTURER RECOMMEDED DOSAGE WILL BE ADMINISTERED
(Requires parent signature ONLY at bottom of page)**Directions:_____**

II. Administer _____,
A **prescription medication,** which I am hereby supplying the school in **the original prescription vial**, in accordance with the directions for the administration of the medicine listed on the label of the vial.
(Requires parent and physician's signature)

III. I will assume responsibility for safe delivery of the medication to school
IV. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment. (NEW PERMISSION FORM AND/OR DR. SIGNATURE REQUIRED)
V. Medications must be picked up at the end of school year by parent, or medication will be destroyed.

I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____ _____
Parent with Legal Custody or Guardian Date

Work Phone _____ Home 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: _____