South Bend Community School Corporation
AUTHORIZATION TO ADMINISTER MEDICATION

Student Name: _____ School: _____

Grade: _____ D.O.B.: _____
Month/Day/Year

***To be completed by the PHYSICIAN/PRACTITIONER for PRESCRIPTION/MAINTENANCE medication:**

1. MEDICATION NAME: _____Diagnosis:_____

   DOSAGE: _____ TIME: _____ ROUTE: _____

   Termination date of medication: _____ OR End of School Year: ☐

2. MEDICATION NAME: _____Diagnosis:_____

   DOSAGE: _____ TIME: _____ ROUTE: _____

   Termination date of medication: _____ OR End of School Year: ☐

3. MEDICATION NAME: _____Diagnosis:_____

   DOSAGE: _____ TIME: _____ ROUTE: _____

   Termination date of medication: _____ OR End of School Year: ☐

PHYSICIAN/PRACTITIONER SIGNATURE: _____

PHYSICIAN/PRACTITIONER NAME (PRINTED): _____

DATE: _____

I request that my child, _____, be assisted in taking this medication at school by authorized and trained personnel, and will comply with the policies and procedures of SBCSC. I give my consent for the school nurse to communicate with the supervising physician and to counsel with the school personnel regarding the possible effects of the medication.

***Medication must be in the original container and brought to school by an adult!**
***Medication must be picked up by an adult.**
***If medication is not picked up by the end of the school year, I authorize the healthcare staff to dispose of any un-used medication.**

Parent/Guardian Signature: _____ Date: _____