SOUTHWEST ALLEN COUNTY SCHOOLS
FORT WAYNE, INDIANA

MEDICATION PERMIT GRADES 9-12

For the safety of our students, our school must observe certain regulations in administering any medications.
WRITTEN PERMISSION IS REQUIRED FOR ALL MEDICATIONS, whether prescription or "over-the counter". Medications MUST be brought to the clinic and given out from the clinic where it can be supervised. We will dispense medications on a daily, routine or "as-needed" basis, as you request. In either case, we will need the specific information noted below.

PRESCRIPTION MEDICATIONS:
MUST BE IN AN OFFICIALLY LABELED CONTAINER: A duplicate container can be obtained at your pharmacy, usually at no extra cost. The container must: 1)Have a current date; 2)State your child's name; 3)State the medication name and strength; 4)State the amount and time to be given.

OVER-THE-COUNTER MEDICATIONS:
PLEASE SEND IN THE ORIGINAL CONTAINER: If the amount requested to be given differs from the recommended dosage, a doctor's permission note must accompany it. **Medication must be age appropriate unless otherwise approved by your doctor.**

INDIANA CODE:
Indiana law limits the ability to send home a student medication that the parent has sent to school to be administered to the student during school hours. A school corporation may release medication for students in grades kindergarten through grade 8 to the student's parents or an individual who is at least 18 years of age **AND** designated in writing by the student's parent to receive the medication.

I give permission for _____ **to transport** _____
(name of student) (name of medication)
to the school nurses office and home from school.

Parent/Legal Guardian
Signature_____ **Date**_____

STUDENT MEDICATION PERMIT

Student Name_____

Age_____ **Weight**_____ **Grade**_____ **Teacher**_____

Condition/Ailment_____

Medication_____ **Expiration Date**_____

Amount to be given _____ **Time to be given** _____

May be repeated every_____ **(or mark N/A)**

TWO HOUR DELAY DAYS:
Medication *will be* given at the first designated prescribed time unless the parent/guardian has contacted the school nurse to make other arrangements.
As parent/guardian, I accept the legal responsibility for the safe arrival of my child's medication to his/her school.

Parent/Legal Guardian
Signature_____ **Date**_____