RIVER FOREST COMMUNITY SCHOOL CORPORATION

School Health Services
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AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION IN SCHOOL

Prescriber's Statement:
I have prescribed the medication(s) indicated below for _____
(Student's Name and Date of Birth)
and do hereby authorize the nurse, nurse assistant, principal or their designee of RFI/MEISTER/EVANS/RF Jr-Sr HS to administer the medication(s) as indicated below:

(1) Medication:_____ Dosage_____
Amount in Tablets_____ Times(s) for administration_____
Reason for taking medication_____

(2) Medication:_____ Dosage_____
Amount in Tablets_____ Times(s) for administration_____
Reason for taking medication_____

STUDENT ALLERGIES_____

If medication(s) is not given at the designated time, when can medication(s) be administered? (½ Hour 1 Hour Not at all) after.
Circle one
Special instructions for administration:_____
Possible side effects to observe and report:_____
Need to carry inhaler: Yes____ No_____
Regarding self-medication (this approval is only for inhalers, epi-pens, insulin or other emergency medication)
_____This student has approval to possess and self-administer this medication
_____This student has been instructed on how and when to self-administer this medication

Date medication administration begins:_____ Date administration ends:_____

Date:_____ Prescriber's Signature_____
_____
(Address and phone number)

Parent Authorization:

I/We _____as the parent/guardian of _____
(Parent/Guardian) (Student Name)

do hereby authorize the nurse, nurse assistant, principal, or their designee of RFI/Meister/Evans, RF Jr.- Sr. HS to administer the above prescribed medication for my child in accordance with the instructions provided. I understand that I will be responsible for supplying this medication(s) to the school in the original container. I further understand that pursuant to Indiana Law (I.C. 34-30-14-2), that authorized school employees who administer such medication in good faith are not liable for civil damages due to such administering of medication. In addition, it is the student's responsibility to come to the nurse's office for the medication unless he/she is physically unable to do so.
Date:_____ Parent/Guardian Signature_____ Phone_____

Note: This authorization is valid only for one school year. After one school year the medication(s) cannot be given unless the authorization is renewed.
Medication must be brought to school by the parent/guardian. Medication must furnished in the original container. Medication not retrieved by the parent/guardian at the end of the school year will be discarded.
Should a change in any of the above information occur, a revised authorization statement must be submitted.