Written Consent for Administration of Medication

In order to protect the health and welfare of the students and school staff alike, Indiana law requires that parents' consent in writing to the administration of medication. In order for the school nurse, volunteer school nurse, or a staff member to administer medication to your student, the form below must be read and signed.

1. The school **must have on record written consent from the parent/guardian for all medications.** No medications (including cough drops) will be administered without consent.
2. Medications prescribed and/or OTC meds should be kept in original container with the pharmacy or brand label affixed. The label must include the following:
    a. Student's Name
    b. Name of Medication
    c. Dosage of Medication
    d. Prescribing Physician/Practitioner (if applicable)
3. Medication brought to the school must be checked in and kept with the office (or teacher).
4. The school nurse/assigned staff member must be aware of the purpose for which the student is receiving the medication.
5. In specific cases, the school nurse/assigned staff member may require the parent/guardian to come to the school to administer the medication.
6. All prescribed medication will be administered strictly in accordance with the written order of the physician/practitioner. The dosage may be changed only if the school is provided with the written order of the physician/practitioner authorizing the change. The school nurse/staff member cannot take a physician/practitioner order over the phone.
7. OTC medication will not be administered in any manner inconsistent with the instructions on the brand label, unless the school receives a written order of a physician/practitioner authorizing such administration.

I have read and understand the above policy.

_____Please administer to my child, _____, the prescribed/over-the-counter medication(s) written below, in accordance with the written order of the physician/practitioner.

AND/OR

_____Please administer to my child, _____, the over-the-counter medication(s) as described below.

Medication	Dosage (Mg and # of tabs)	Time	Precautions/Side Effects
1.			
2.			
3.			
4.			

Period of time medication is to be continued: _____

Reason for medication: _____

Parent/Guardian Signature: _____Date:_____

Printed Name:_____Phone #:_____

RLA Health Plan

In order to meet the health needs of my child,_____, please administer care by the following the outlined plan during the effective dates listed below:

Start Date:_____ End Date:_____

	Health Need	Response Plan
Allergies	(e.g. allergic to nuts)	(e.g. avoid nuts in snacks/meals, administer epi-pen upon ingestion)
Nutritional Needs	(e.g. gluten free)	(e.g. no gluten snacks)
Respiratory Treatments	(e.g. asthma)	(e.g. administer inhaler upon breathing troubles)
Other		

Parent/Guardian Signature: _____Date:_____

Printed Name:_____Phone #:_____