



Hamilton Community Schools
 903 South Wayne Street
 Hamilton, IN 46742
 Phone: 260.488.2101 Fax: 260.488.3149

2021-2022 School Year

Authorization for Administration of Medication at School

Student: _____ Grade: _____ Teacher: _____

Medication: _____ Dose: _____

Time of Administration: _____ AM/PM Date Medication to be discontinued: _____

- _____ has permission to bring this medication home.
 (Student name) Initials: _____

- _____, an adult (18) years of age or older, has my permission to
 (Name) bring this medication to me.
 Initials: _____

How Taken:

- By Mouth
- Inhaled
- Patch
- Injection
- Other _____

Medical Condition:

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- ❖ I assume the responsibility for the safe transport of this medication to school.
 - ❖ I request the medication be given on field trips, as prescribed.
 - ❖ I release school personnel from liability should administering this medication result in an adverse reaction.
 - ❖ I will notify the school, in writing, of any change in the medication (dosage change, med discontinued, etc.)
 - ❖ I give permission for the school nurse to communicate with student's teacher, physician and necessary school staff about child's health condition and the action of the medication.
 - ❖ I give permission for the medication to be given by the designated personnel (the school nurse may not always be present in the school).
 - ❖ I certify that I am the parent, legal guardian, or other person in legal control of the above identified student. I read and understand the information within this authorization and the procedure for administration of medication at school.

(Signature of Parent/Legal Guardian)

(Telephone Number)

(Date)