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

23-24 School Year

Authorization for Administration of Medication at School

Student: _____ Grade: _____Teacher: _____

Medication: _____ Dose: _____

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

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

How Taken:

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

Medical Condition:

- ❖ 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)