WESTVIEW SCHOOL CORPORATION
1545 S 600 W
Topeka, IN 46571

Student Name: _____ Grade:_____

School: _____

Authorization to Possess and Self-Administer Medication

In accordance with Westview School Corporation's Policy 5330.01 and Indiana codes 20-8.1-5.1-7.5 and 34-30-14-6, A student may possess and self-administer medication for chronic diseases or medical conditions provided the student's parent files a written authorization with the principal annually. A physician's written statement must be included with the parent's authorization.

The physician statement shall include…

1) An Acute or Chronic disease or medical condition exists for which the medication is prescribed
2) The student has been given instruction as to how to self-administer the medication
3) The nature of the disease or medical condition requires emergency administration of the medication

The School or School board is not liable for civil damages as a result of a student's self-administration of medication for an acute or chronic disease or medical condition except for an act of omission amounting to gross negligence or willful and wanton misconduct.

The following form completed in its entirety will ensure compliance with Westview School Board policy.
A physician's section can be completed on the back and fax to:_____
or on a physician's note with date, time, physician's signature that includes all three above criteria.

PARENT SECTION:

Please allow my child, _____ to possess and self administer_____ (Name of Medication).

I will assume all responsibility for my child's medications ensuring my child knows how to transport medication, use medication appropriately, store and secure medication, and will not hold Westview School or School Board accountable for any misuse of medication.

Parent Signature_____Date_____

Printed Parent Name_____

PHYSICIAN'S SECTION

The following student,_____ (students name), has been diagnosed with _____medical condition. This condition warrants that this student have access to emergency administration of medication.

The Following medication has been prescribed for this instance.

Name of Medication: _____

Dose: _____Frequency: _____

The above student has been given instructions and trained on how to safely administer medication. I acknowledge that the student knows the nature of the medication and its use and the dose and frequency of its use and have verified that the student can properly administer and self posses the above medication.

Physician's Signature: _____ Date: _____

Printed Physician's name: _____

SCHOOL ADMINISTRATION'S SECTION

I acknowledge that this student, _____, has met the requirements to possess and self administer medication and authorize this student to possess and self administer the above medication for the _____ school year.

Principals Signature: _____ Date:_____

Printed Principals Name: _____