JAC-CEN-DEL
COMMUNITY SCHOOLS

4544 N US 421
Osgood, Indiana 47037
www.jaccendel.k12.in.us
Telephone: (812) 689-4144 ◦ Fax: (812) 689-5909

Parent/Doctor Authorization to Give Medications

PRESCRIPTION medications must be provided in the original container and label intact.

NON-PRESCRIPTION medications will only be administered with a parent note.

- ☐ Student's Name: ____
- ☐ Name of Medication: ____
- ☐ Dosage: ____
- ☐ Time to be Administered: _______________________________________
- ☐ Reason for Medication: ____

Parent/Guardian Consent

This certifies that I, the undersigned Parent/Guardian, am aware of the above authorization and hereby request that appropriate school personnel carry it out accordingly. I agree to notify you immediately of any change in circumstances concerning the administration of this medication I give permission for this information to be provided to the appropriate school personnel to best meet my student's educational needs.
Parent/Guardian Signature: ________________________________ Date: ________________________

Physician Consent

(for prescriptions only)

This certifies that I, the health care provider, am aware of the results for the above named medication to be administered while at school. It is with my permission that the nurse or toher designated school employees shall be allowed to dispense this medication.
Physician Signature: ____________________________________ Date: ________________________

Doctor to check box if he/she feels as though student is responsible enough to carry and administer medication without supervision. ☐

Superintendent of Schools
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Elementary Principal
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