Student's Name: ____ **Date of Birth:** ____________________

PHYSICIAN/PRESCRIBER CONSENT FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION
(Residential & Non-Residential Students)

(IF APPLICABLE)

- **This section MUST be completed by the prescriber (not the parent/guardian)**
- One page per Prescriber – please complete all columns
- Prescription medication includes: oral medication including birth control pills/patches, insulin, epipens, inhalers, nasal sprays, topical creams/lotions/gels & eye/ear drops
- Note…per school policy, "controlled" medication is not permitted in student dorm rooms & therefore is not allowed to be self-administered (even if marked "yes" below)

Medication (name/dosage/route/frequency)	**As Needed?** (please circle)	**Diagnosis**	**Consent for Self Administration** (please circle)
	YES or No		YES or No
	YES or No		YES or No
	YES or No		YES or No
	YES or No		YES or No

<u>Physician/Prescriber:</u>

Provider Signature: ______________________________________ Printed Name: ___________________________

Address: ____

Phone #: ___________________________ Fax #: __________________________ Date: ____________________

PARENT CONSENT FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION
(Residential & Non-Residential Students)

- One page per Prescriber
- Please see "FYI Page 4" for an overview of our medication policy

I, the parent/guardian, give consent for my child to self-administer the above medication in compliance with the Indiana Academy Medication Policy? __________ YES __________ NO

(If there are meds you <u>do not</u> want your child to self-administer, please list those medications here:

Parent/Guardian Signature: ____

Printed Name: ____ Date: ____________________

CC: Tina Brinkman, RN/Nikki Al Khatib, RN