THE INDIANA ACADEMY
FOR SCIENCE, MATHEMATICS, AND HUMANITIES

PRESCRIPTION MEDICATION FORM 2025-2026

CONSENT FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Name **Date of Birth**

To be filled by prescriber: **Medication** (name/dosage/route/frequency)	*To be filled by prescriber:* **Diagnosis**	**Prescriber Consent**	**Parental Consent**
		YES NO	YES NO
		YES NO	YES NO
		YES NO	YES NO
		YES NO	YES NO
		YES NO	YES NO
		YES NO	YES NO
		YES NO	YES NO
		YES NO	YES NO

Physician/Prescriber: Please complete the first three columns & sign below.

Signature: Date:

Printed Name:

Address:

Parent/Guardian: Please complete the last column & sign below.

Signature: Date:

Printed Name:

- Each prescription medication requires parent/guardian and provider consent for self-administration privileges.
- School policy does not allow controlled medication to be self-administered.
- Over the counter medication does not need to be added to this form.

Nicola Al Khatib RN Fax: (765)285-0063 nalkhatib@bsu.edu 2025-2026