THE INDIANA ACADEMY FOR SCIENCE, MATHEMATICS, AND HUMANITIES

2020 - 2021

Student's Name: _____

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

- **Columns 1 thru 4 MUST be completed by the prescriber & column 5 MUST be completed by the parent/guardian**
  - One page per Prescriber – make additional copies of page if needed
- **ALL** prescription medication must be included below (*oral medication, birth control pills/patches, insulin, inhalers, nasal sprays, epinephrine (epipen/auvi q), topical medication, eye/ear drops)*
  - School policy does not allow "controlled" medication to be self-administered, even if consent is given below

(1) ***Prescriber*** **List ALL Medication** (name/dosage/route/frequency	**(2)** ***Prescriber*** **As Needed?** (please circle one)	**(3)** ***Prescriber*** **Diagnosis** (please list)	**(4)** ***Prescriber*** **Consent for Self Administration** (please circle one)	**(5)** ***Parent/Guardian*** **Consent for Self Administration** (please circle one)
Example: Singulair 10mg 1 tab po daily Example: ProAir 2 puffs every 4 hours Example: Retin A apply to face daily	Routine As Needed Routine	Allergies Asthma Acne	Yes Yes Yes	Yes Yes Yes
	Routine OR As Needed		Yes OR No	Yes OR No
	Routine OR As Needed		Yes OR No	Yes OR No
	Routine OR As Needed		Yes OR No	Yes OR No
	Routine OR As Needed		Yes OR No	Yes OR No
	Routine OR As Needed		Yes OR No	Yes OR No
	Routine OR As Needed		Yes OR No	Yes OR No
	Routine OR As Needed		Yes OR No	Yes OR No
	Routine OR As Needed		Yes OR No	Yes OR No
	Routine OR As Needed		Yes OR No	Yes OR No
	Routine OR As Needed		Yes OR No	Yes OR No
	Routine OR As Needed		Yes OR No	Yes OR No

Physician/Prescriber: *complete columns 1 thru 4 above & sign below (parent/guardian completes column 5).*
Provider Signature: _____ Printed Name: _____
Address: _____
Phone #: _____ Fax #: _____ Date: _____

Parent/Guardian: *complete column 5 above & sign below (prescriber completes columns 1 – 4).*
Parent Signature: _____ Printed Name: _____ Date: _____

FYI: parent/guardian & prescriber
THE INDIANA ACADEMY NURSING STAFF WOULD BE HAPPY TO ASSIST IN FILLING YOUR STUDENTS MONTHLY OR "AS NEEDED" PRESCRIPTION MEDICATION. IN ORDER TO DO SO, WE WILL NEED THE FOLLOWING:

- ***Written prescriptions*** *for each medication above that you wish to be filled by the IASMH nursing staff. Preferably the scripts should be written to cover at least the first semester of school.*

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