THE INDIANA ACADEMY
FOR SCIENCE, MATHEMATICS, AND HUMANITIES

PRESCRIPTION MEDICATION FORM

CONSENT FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Student Name _____ Date of Birth _____

To be filled by prescriber: **Medication** (name/dosage/route/frequency)	*To be filled by prescriber:* **Diagnosis**	**Prescriber Consent for Self-Administration**	**Parental Consent for Self-Administration**
		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: _____ Printed Name: _____

Address: _____

Phone #: _____ Fax #: _____ Date: _____

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

Signature: _____ Printed Name: _____ Date: _____

- 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.

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