**PRESCRIPTION MEDICATION FORM-CONSENT FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION**

Student’s Name Date of Birth

|  |  |  |  |
| --- | --- | --- | --- |
| **List ALL medication**(name/dosage/route/frequency)(Prescriber) | **Diagnosis**(Prescriber) | **Consent for Self-Administration**(Prescriber) | **Consent for Self-Administration**(Parent) |
|  |  | 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:

* ALL prescription medication must be included above. School policy does not allow “controlled” medication to be self-administered, even if consent is given.
* The Indiana Academy Nursing staff would be happy to assist in filling your student’s monthly or “as needed” medication. We will need to know where the medication will be sent to be filled. The local options are CVS, Walgreens or the health center pharmacy.