WASHINGTON TOWNSHIP SCHOOLS

Medication /Treatment Authorization

Student Information			
Student's Last Name (Printed)	Student's First Name (Printed)	Date of Birth	School/Grade

Medication/Treatment Information			
Name of Medication/Treatment (One per form)	Strength (mg, units, etc)	Start Date	End Date

Dosing Schedule	
Time of Day (Scheduled/PRN)	Please specify the symptoms for which this medication should be given (if PRN)
Amount	

Special Instructions

Medication expiration date & other info:

Please skip to Self-Administer or Parent Authorization if non-prescription.

Prescription Information

I am requesting that an authorized representative of the MSD Washington Township administer the following prescribed or OTC medication or treatment. Prescription medication in the original container required. A copy of the prescription label may be attached, or the nurse may write the information from the prescription label below. The nurse will verify that the student name, medication, dosage, strength and dosing schedule are accurate. **I understand that a prescription for low THC Hemp Extract will not be administered to my child unless all requirements of the MSDWT Administrative Guidelines 5300 –Use of medications are met.**

Authorization to Carry/Self-Administer Medication (Physician Signature Required)

I indicate by signing below that the student named above is a patient under my care who has an acute or chronic medical condition for which the forenamed medication has been prescribed. The student may possess and self-administer the medication. The student has been instructed in how to self-administer the medication. The nature of the disease or medical condition requires emergency administration of the medication. (IC 20-33-8-13) Physicians may state self-carry on an Action Plan.

Physician Signature/Phone Number	Student may carry and self- administer med: ____Yes ____No	Student may carry but need help administering med: ____Yes ____No	Date

Parent Authorization (all medications)

Parent Name (Printed)	Parent Signature	Date

Parent Phone Number

- For all students' grades K-8 and preschool, I will assume responsibility for safe delivery to the school health clinic at the beginning of the school year and retrieval from school at the end of the school year. **Preschool and students' grades K-8 MAY NOT transport medication(s) to and from school.** Medications left at school following the close of the school year will be destroyed.
- **North Central High School Students may transport medication(s) to and from school if this form (5330 F/B) is on file and signed by the parent/guardian**. Medications left at school following the close of the school year will be destroyed.
- I will notify the school in writing if there is any change in the use of the medication(s)/treatment.
- **PERMISSION IS VALID ONLY FOR THE CURRENT SCHOOL YEAR AND ONLY FOR THE STUDENT LISTED ON THE FORM. STUDENTS ARE NOT PERMITTED TO SHARE THEIR MEDICATION WITH OTHER STUDENTS. VIOLATIONS WILL RESULT IN DISCIPLINARY ACTION.**

WASHINGTON TOWNSHIP SCHOOLS

Medication /Treatment Authorization

Medication Refill			
Date	Qty	Parent/Guardian Signature	Clinic Provider Signature/Staff Witness
Date	Qty	Parent/Guardian Signature	Clinic Provider Signature/Staff Witness
Date	Qty	Parent/Guardian Signature	Clinic Provider Signature/Staff Witness
Date	Qty	Parent/Guardian Signature	Clinic Provider Signature/Staff Witness
Date	Qty	Parent/Guardian Signature	Clinic Provider Signature/Staff Witness
Date	Qty	Parent/Guardian Signature	Clinic Provider Signature/Staff Witness
Date	Qty	Parent/Guardian Signature	Clinic Provider Signature/Staff Witness
Date	Qty	Parent/Guardian Signature	Clinic Provider Signature/Staff Witness

Medication/Treatment Notes

____

____

____

____

____

____

____

____