Seymour Community Schools

MEDICATION/TREATMENT AUTHORIZATION FORM

Student's Name: _____ Date of Birth:_____

The following section is to be completed by the parent or legal guardian:

List child's health condition and allergies: _____

_____

Name of medication: _____ ☐ School supplied medication

Expiration date:_____ Amount to be given: _____ Time(s) to be given:_____

Date to start: _____ ☐ Date form signed Date to end: _____ ☐ End of school year

Please initial below to give permission to administer the following school supplied medications and authorize administration with your signature below. Medication will be administered in accordance with school policy:

____ Antacid
____ Cough Drops
____ Ibuprofen (*only ages 12 and up*)
____ Orajel
____ Sunscreen
____ Triple Antibiotic Ointment
____ Tylenol
_____ Pepto-Bismol
_____ Loradamed (allergy medicine)

Prescription medicine **MUST** have original, unaltered prescription label on the bottle; this label will include the child's name, medication, dosage, frequency of administration, doctor's name, pharmacy's name and phone number.

Non-prescription medicine **MUST** be in original (store labeled) container, also marked with the student's name. Medication dose cannot exceed dose specified on medication label without a physician's order. No Aspirin, aspirin products and/or naturopathic products will be given without a physician's order.

I hereby grant permission to the school nurse, principal or the trained school-designated staff to assist in the administration of the prescribed medication and/or treatment to my child while in school and away from school while participating in official school activities.

Parent/Guardian Signature: _____ Relationship:_____ Date:_____

Home Phone #:_____Work Phone #:_____Cell Phone #:_____

This consent form was designed to comply with the provisions of Indiana Code 34-4-16.5-35 and amendments thereto, and Rule 51 of Commission on General Education.