Northeastern Wayne Schools Medical Authorization

Health Care Providers: Please mail this Authorization to the School Nurse at:

☐ Northeastern Elementary School
534 W Wallace Rd
Fountain City, IN. 47341

☐ Northeastern MS/HS
7295 US 27 N
Fountain City, IN. 47341

Student's Name ______________________________ DOB: ______________

Grade: ____________ Homeroom Teacher: ______________

List any drug allergies/adverse reactions: ______________________________

PARENT OR LEGAL GUARDIAN AUTHORIZATION ***(FOR ALL MEDICATIONS)***

If a medication must be given during school hours, this form must be completed. The parent/guardian must provide the school with the FDA approved over the counter or prescription medication in its original container with unexpired date which will be given as directed on the container or as directed by the physician below. It is the responsibility of the parent/guardian to notify school personnel of medication changes and to complete a new Authorization.

Name of Medication: ______________ Dosage: ________
Time of Day to be Given: _____ am/pm or as needed
Beginning (date) ___________ to (ending date) __________ (not to exceed current school year).

Medications must be delivered to the school nurse, principal and/or the school designee according to INDIANA SENATE BILL #376 (effective 7/01/2001). Medications must be delivered in their original container and properly labeled with the student's name, name of medication, unexpired date, and instructions re: dosage, time/frequency of administration.

My permission is hereby granted to the Northeastern Wayne School staff to assist my child in the administration of the named medication in accordance with Northeastern Wayne School's medication policy. I hereby release and discharge the Northeastern Wayne School and staff from any liability whatsoever that might result from administering or not administering medication.
I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act (HIPAA) disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served in in attendance in the Northeastern Wayne Schools. This authorization expires as of the last day of the current school year.

Date ____________ Parent/Guardian Signature ______________________________

Cell Phone ______________ Work Phone ____________ Home Phone ____________

PHYSICIAN/DENTIST AUTHORIZATION ***(FOR PRESCRIPTION MEDICATIONS ONLY)***

Student Name: ____________________ Condition/Illness Requiring Medication: ____________

Medication: ________________ Dosage: ______________ Route: ____________

Frequency/Time to be given: ______________________________

Start Medication on: ________________ Stop Medication on: ______________

Common Side Effects of Medication: ______________________________

Student may carry and self-administer medication due to a life-threatening condition: YES NO

Special Instructions: ______________________________

Physician/Dentist Signature: ________________ Date: ______________

Telephone Number: ________________ Address: ______________