Request for Student to Possess and Self-Administer Medication

A student may possess and self-administer medication for a chronic disease or medical condition only if the parent/guardian annually files with the principal or school nurse written authorization from both the parent/guardian and the student's physician.

Parent/Guardian Authorization

I am the ***Parent / Guardian*** (circle one) of the student identified below. I authorize the Indianapolis Public Schools to permit the designated student to possess and self-administer the medication identified below on school property and during school hours.

______________________________	___/___/___	____________________
Student Name (Please Print)	Birthdate	School

______________________________	______________________________
Name of Medication	Purpose of Medication
______________________________	______________________________
Signature of Parent/Guardian	Date
______________________________	______________________________
Printed Name	Phone

Physician Statement

I am a licensed health care provider who provides medical services to ______________________________.
Name of Student

I have prescribed ______________________________ for this patient.
Name of Medication

I certify that the following statements are true and accurate:

- An acute or chronic disease or medical condition exists for which the above-named medication is prescribed
- The student named above has been given instructions as to how to self-administer the medication
- The nature of the disease or medical condition requires emergency administration of the medication

______________________________	______________________________
Physician's Signature	Physician's Phone
______________________________	______________________________
Physician's Name Printed	Date
______________________________	______________________________
Physician's Address	City, State