

**PERMISSION FORM FOR
 AUTHORIZATION OF SELF-ADMINISTRATION OF MEDICATION**

Greater Clark County School Corporation requires that parents of all students with a chronic disease or medical condition who must possess and self-administer medication during school hours shall do the following:

1. Return this completed PERMISSION FORM signed by both the parent/legal guardian and the licensed healthcare professional. (A new form must be filed each school year.)
2. The medication must be in the original prescription bottle/container and properly labeled with:
 - a. Name of student
 - b. Name of medication
 - c. Name of licensed healthcare professional
 - d. Directions to administer medication:
 - ✓ amount to be taken
 - ✓ when to take medication
 - ✓ route of administration (oral, topical, inhaled, etc.)

TO BE COMPLETED BY PARENT/GUARDIAN	
Student's Name _____	Date of Birth _____
Address _____	School _____
I give my permission for my child to possess and self-administer the medication as described below.	
Parent/Guardian Signature _____	Date _____

TO BE COMPLETED BY LICENSED HEALTHCARE PROFESSIONAL	
My signature below certifies that: (1) The above-named student's disease/medical condition requires emergency administration of medication; (2) The student needs to possess and self-administer medication during school hours; and (3) The student has been instructed and knows how to properly self-administer the medication.	
Name of medication _____	
Specific time(s) & dose(s) to be medication is to be used at school _____	
Duration of usage _____	
Chronic disease/medical condition requiring self administration of medication _____	
Signature of Licensed Healthcare Professional _____	Date _____
Printed Name of Licensed Healthcare Professional _____	
Address _____	Telephone # _____

For Office Use Only: School Year _____ - _____ Date Filed _____

