SOUTH SD DEARBORN
Community School Corporation

6109 Squire Place, Aurora, IN 47001 www.sdcsc.k12.in.us T: 812-926-2090 F: 812-926-4216

MEDICATION PERMIT FORM

School _____ School Year _____ Today's date _____

STUDENT NAME_____ DOB_____Grade_____

Drug Allergies _____

Doctor's Name:_____Phone number _____

Drug Name:_____

Drug Dose: _____ Frequency: _____

Number of days for drug to be given:_____
(Ex. 7 days, 2 weeks, school year, etc.)

REASON FOR MEDICATION:_____

SPECIAL CONCERNS:

Self-administration of medication requires a physician's signature:

The above named student may self-administer the above listed medication(s) in accordance with my prescription.

Physician's Signature: _____ Date: _____

I give SDCSC personnel permission to administer medicine as listed above during school hours. I understand that it is my child's responsibility to come to the office for the medicine. I also understand that it is my obligation to provide any and all medicines, keep the school aware of any changes in the medication, deliver medications to the office and pick up any unused medications.
Any unused medication:

____ May be sent home with the above student at the end of the school year. (Please note that we cannot send controlled substances with students.)

____ Will be picked up by a parent/guardian.

____ May be destroyed at the end of the school year.

_____
(Signature of Parent/Guardian) (Date)

Success Driven. Grow. Excel. Achieve.
A Community Commitment