PRESCRIPTION MEDICATION

PHYSICIAN PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

2023-2024

COMPLETED BY PHYSICIAN – COMPLETED BY PHYSICIAN – COMPLETED BY PHYSICIAN – COMPLETED BY PHYSICIAN

Name of Student _____

Please indicate which school your patient attends:

☐ West Lafayette Elementary
Nurse (765) 269-4105
Fax (765) 464-3210

☐ West Lafayette Intermediate
Nurse (765) 269-4304
Fax (765) 405-7038

☐ WL Jr / Sr High School
Nurse (765) 746-0419
Fax (765) 360-8001

I authorize the above named school to administer the following medication:

Medication	Route	Dose	Frequency	Duration (Dates)

Physician's Signature _____

Physician's Printed Name _____

Parent signature required in order to dispense above medication

THE MEDICATIONS INDICATED ABOVE
MAY BE ADMINISTERED TO MY CHILD

_____ _____
(Signature of Parent / Guardian) (Date)

The above signature acknowledges that the school corporation and its employees assume no responsibility or liability for the prescription of medication, the dosage prescribed, or any consequences, directly or indirectly resulting from the administering of such medication in accordance with the instructions set forth above. The above signed further, both individually and as a parent and/or guardian of the above named child, does hereby waive and release any claim against the West Lafayette Community School Corporation or its employees resulting from the administering of such medication in accordance with the instructions set above.

_____ _____
School Nurse Date received by Nurse