# CLINTON PRAIRIE SCHOOL CORPORATION
# PERMISSION TO SELF ADMINSTER MEDICATION

Date: _____

Dear Prescriber,

The parent or guardian of _____, birth date of _____

requests that their child be allowed to possess and self administer the medication

_____.

Please assist us in compliance with Indiana Code 20-8, 1-7-22 which requires the school to have the parent and physician's permission for the student to carry emergency medication on their person. The following questions are state required. Please complete ***A*** and initial ***B*** and ***C*** .

A. The name of the acute or chronic disease or condition for which the medication has been prescribed: _____
B. The student has been instructed on self administration of the prescribed medication. _____
C. The nature of the disease or condition requires emergency administration of the medication. _____

Prescriber signature: _____

Date: _____

Parent or guardian's signature: _____

Date: _____

PLEASE FAX or MAIL TO: Clinton Prairie Schools
c/o Judy Clark, RN
2500 S. County Road 450 W.
Frankfort, IN 46041-7414
FAX: 765-659-9560