

**PRESCRIPTION MEDICATION**  
**PHYSICIAN PERMISSION TO ADMINISTER MEDICATION AT SCHOOL**  
**2019-2020**

**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) 746-0422

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**

<b>THE MEDICATIONS INDICATED ABOVE MAY BE ADMINISTERED TO MY CHILD</b>	
_____ (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