West Lafayette Community School Corporation
Form for Student to Carry and Self-Administer Emergency Medications

In accordance with P.L. 264 Section 2 IC 20-8, 1-5.1 - 7.5, students may carry and self -administer medication **ONLY IF** the following conditions are met:

1. A physician's written statement indicates that the student has a chronic or acute condition for which medication has been prescribed.
2. A physician's statement indicates that the student has been instructed in how to administer the medication.
3. A physician's statement indicates that the nature of the student's condition requires emergency administration of the medication.
4. The parent must file their written permission and the physician's written statement with the school annually.

To be Completed by the Physician:

Student's Name ______________________________ *School Year* ______________ *Grade* ______

Medical Condition for Which Medication is Prescribed ________________________________

____

Medication Prescribed ____

Dose and Time ____

This condition requires emergency administration of the medication? Yes _____ No _____

The student has been instructed in administration of medication? Yes ______ No _______

The student is allowed to carry and self-administer this medication? Yes _____ No ______

Additional instructions: ____

____

Physician's Signature: _________________________________ Date: ____________

As the Parent/Guardian of the above named student, I have read and agree with the physician's statement above and give my permission for my student to carry and self-administer the medication noted in the physician's statement above. I acknowledge that the school corporation and its employees assume no responsibility or liability for the prescription for medication, the dosage prescribed, or any consequences, directly or indirectly resulting from the administering of such medication in accordance with instructions set forth above. The undersigned 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 instruction set forth above. I agree that the corporation is not responsible for lost and/or stolen medication.

Parent/Guardian's Signature: _______________________________ Date: ____________

WLCSC Health Services 04/04, revised 04/09