

**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:** \_\_\_\_\_