Nineveh Hensley Jackson School Corporation
Indian Creek Health Services - 317-878-2108
Consent for Administration of Medication

Student's Name_____Grade_____ DOB_____

Medication Name:_____
Dose:_____
Time(s) to be given:_____
Daily or As Needed:_____

All prescription medication MUST be supplied in the original, labeled prescription container.
All over-the-counter (OTC) medications MUST be supplied in the original, unexpired container.

See School Handbook for complete guidelines for Medication Administration during school.

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as indicated above.
2. I will notify the school clinic of any change in the medication(s), i.e., dosage change, medication is stopped, etc.
3. I give permission for the medication(s) to be given by trained school personnel when delegated by the school nurse in his/her absence or while attending a field trip.
4. I release school personnel from liability in the event adverse reactions result from taking this medication.
5. This consent may be revoked at any time by sending a written notice to the school nurse.

Parent/Guardian Signature_____ Date_____

For High School Students ONLY (Grades 9-12)

I give the ICHS clinic staff permission to send the above medication (this does not include controlled substances) home with my child at the end of the school year or when this medication is no longer needed to be given at school.

Parent/Guardian Signature_____ Date_____