BARTHOLOMEW CONSOLIDATED SCHOOL CORPORATION

ADMINISTRATION BUILDING
1200 Central Avenue
Columbus, IN 47201

Prescription Medication

RE: School Personnel at (Name of School)_____

RE: Administration of Medication to (Student's Name) _____

This notice is to inform you that the above named student, enrolled in your school, is currently under my medical care. As a part of that care, this student must receive the following medication for the medical indication listed, at the dosage, route and interval prescribed below.

Medical Diagnosis: _____

Medication: _____

Dosage, Interval and route: _____

Length of therapy: _____

Additional information _____

_____

I request and authorize you to administer this medication in accordance with the above instructions. Problems concerning administration of this medication can be referred to me at:

Date _____ Physician's Signature _____

Address _____ Telephone _____

We, as the parent(s) of _____ request, authorize and give written permission to you to administer the medication described in accordance with the instructions provided.

We agree to notify you immediately of any change in circumstances concerning administration of this medication.

Parent Signature: _____ Date:_____

Address: _____

Telephone: _____

BARTHOLOMEW CONSOLIDATED SCHOOL CORPORATION

ADMINISTRATION BUILDING
1200 Central Avenue
Columbus, IN 47201

I, the parent/guardian of _____, give permission to administer the following medications in accordance with the following instructions for dose, interval of dosage and indications for administration:

1. Medication:_____

Dose:_____ Time of Dose:_____

Indications:_____

2. Medication:_____

Dose:_____ Time of Dose:_____

Indications:_____

3. Medication:_____

Dose:_____ Time of Dose:_____

Indications:_____

4. Medication:_____

Dose:_____ Time of Dose:_____

Indications:_____

Parent/Guardian Signature: _____

Address: _____

Telephone: _____ Date: _____