Brownstown Central Community School Corporation
608 West Commerce Street
Brownstown, Indiana 47220

Medication Permission Form

- **ALL** medication given at school requires permission from the physician **AND** parent or guardian.
- Prescription medications must be kept in the original pharmacy bottle with label.
- The pharmacy label can serve as the written order of the physician.

Name of student _____ School _____ Grade _____

Name of Medication_____ Dosage _____ Time _____

Pharmacy_____ Prescription number _____

Diagnosis _____ Prescription expiration date _____

To be completed by the physician:

It is necessary for this medication to be taken during school hours at the above time(s).

Physician's name_____ Telephone _____

Physician's signature _____ Date _____

To be completed by the parent:

I authorize school personnel to administer the above medication to my child and agree that we will not hold liable any member of the school staff or any individual of official capacity who is directed by me and the school nurse to assist my child in taking said medication.

Parent /Guardian signature _____ Date _____

Telephone number to be reached during school hours _____

Permission for student to transport medication home:

I **do** or **do not** (please circle) authorize the school personnel to allow my child to transport home any unused portion of the above medication.

Parent /Guardian signature _____ Date _____