

MT. VERNON COMMUNITY SCHOOL CORPORATION
REQUEST FOR STUDENT TO POSSESS & SELF-ADMINISTER MEDICATION

A student may possess and self-administer medication for a chronic disease or medical condition only if the parent/guardian annually files, with the school, the signed Authorization and Physician's Statement below.

Parent/Guardian Authorization

I am the Parent/Guardian (circle one) of the student identified below. I authorize Mt. Vernon Community School Corporation to permit this student to possess and self-administer the medication identified below on school property and/or school functions.

Student's Name (printed)

Name of Medication

Purpose of Medication

Signature of Parent/Guardian

Date

Printed Name of Parent/Guardian

Phone

Physician's Statement

I am a licensed physician. I provide medical services to _____
(*name of student*) and have prescribed _____ (*name of medication*)
for this patient. I certify that the following statements are true and accurate:

1. An acute or chronic disease or medical condition exists for whom the above named medication is prescribed.
2. The student named above has been given instructions as to how to self-administer the medication.
3. The nature of the disease or medical condition requires emergency administration of the medication.

Physician's Signature

Physician's Phone

Physician's Name (printed)

Date

Physician's Address