

LAFAYETTE SCHOOL CORPORATION
HEALTH SERVICES

Prescriber Permission Form

Date: _____

Dear Prescriber,

The parent or guardian of _____
Birth date of _____ requests that their child be allowed to possess and
self administer the medication _____.

Please assist us in compliance with Indiana Code 20-8, 1-7-22 which requires the
school to have the physician's permission for the student to carry emergency
medication on their person. The following questions are state required. **Please
complete or initial as appropriate.**

A: The acute or chronic disease or condition for which the medication
has been prescribed. _____

B: The student has been instructed on self administration of the prescribed
medication. _____

C. The nature of the disease or condition requires emergency administration of
the
medication. _____

Prescriber signature: _____

Date: _____

PLEASE RETURN TO:

Thank you.

