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