



CROWN POINT HIGH SCHOOL

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Permission to Carry Medication for Emergency Administration Contract

To the Parent:

So that we may provide the best care for your child, please carefully read and complete this form and return it to the school nurse. If any changes occur during the year, contact the school nurse.

Qualified students will be allowed to carry their medication for emergency use.

For permission to carry emergency medication:

1. Student has demonstrated to the doctor the correct use of medication.
2. Student agrees to never share the medication with another person.
3. Student agrees to carry the medication on his/her person.
4. Student agrees that after following the doctor's instructions for use of the medication, he/she will go to the nurse **immediately**.

Student signature _____

I give permission for my child _____ to carry the emergency medication prescribed by his doctor (see back of form). I understand that he/she must follow the rules listed above. I will notify the school of changes in medication or my child's condition. I give the school nurse permission to discuss my child's health condition with school personnel who have a need to know in order to meet the health and safety needs of my child

Parent signature _____ **Date** _____

The back of this form **must** be completed.

To the Physician: Re: New Law-Student Self Administration of Medication

Indiana State Senate enrolled ACT No. 376 Section 1.IC 20-8.1-5.1-0.5 is added to the Indiana Code as a new section effective July 1, 2001: Sec. 7.5 (a) reads in subdivision

- (2) A Physician states in writing that:
- (A) The student has an acute or chronic disease or medical condition for which the physician has prescribed medication:
 - (B) The student has been instructed in how to self-administer the medication; and
 - (C) The nature of the disease or medical condition requires **emergency** administration of the medication.

Please complete the back of this form re: the Emergency Health Care Plan and Medication Order.

STUDENT ACTION CARE PLAN
(Parent to complete)

Student: _____ Birth Date: _____ School Year: _____

Teacher: _____ Room: _____ Grade: _____

EMERGENCY CONTACTS

1. Name: _____ Relationship: _____

Home phone: _____ Work phone: _____ Other: _____

2. Name: _____ Relationship: _____

Home phone: _____ Work phone: _____ Other: _____

PHYSICIAN: _____ Phone: _____

EMERGENCY HEALTH CARE PLAN for CARRYING MEDICATION
(Doctor and Parent to Complete)

DIAGNOSIS: _____

Emergency action is necessary when this student has the following symptoms _____

Steps to be taken during an EMERGENCY episode:

1. Give medication(s) as listed below.
2. Rescue squad/parent will always be contacted.

Name of Medication	Dose	When to Use/How Often
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Special Instructions: _____

Physician signature: _____ Date: _____

Parent signature: _____ Date: _____