South Central Health Services
9808 S. 600 W. | Union Mills, IN 46382
(219) 767-2269 | www.scentral.k12.in.us

Prescription Medication Administration Form

Name ____ DOB _____________________

School ____ Grade ___________

Medication ____ Diagnosis ____________________________

Directions (include route, dosage, and frequency) ____

____

Time(s) to be administered during the school day ____

Order is valid for ☐ 2026-2027 School Year - OR - from________________ to __________________
Date Date

Is this medication to be self-administered? ☐ Yes ☐ No

Please list any expected side effects, contraindications, or adverse reactions:

____

____

Please list other current medications: ____

____

____ __________________
Provider Signature Date

____ ____________________________
Provider Printed Name Phone Number

Parent/Guardian Consent

I, as Parent/Guardian of (student) ____________________________, authorize the School Administrator/School Nurse to direct members of the school staff to assist my child in taking the above medication and agree that I will not hold liable any member of the school staff or an individual of official capacity who is directed to assist my child in taking the above listed medication. Furthermore, I understand that South Central School Health Staff may contact the above-named provider in reference to the above-named medication as needed.

____ ____________________
Signature of Parent/Guardian Date

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Parent/Guardian (Please Print)

Revised 5/2020 DLP, 3/2021 DLP