

Norwell Middle School

1100 E US 224

Ossian, IN 46777

Telephone 1-260-543-2218

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AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT NORWELL MIDDLE SCHOOL

Student Name _____ Grade _____

Medication Name _____ # of Pills/Liquid provided _____

Dosage _____ Time to be Administered _____ How Taken? By Mouth ___ Inhaled ___ Patch ___ Other _____

Reason for Medication _____

All medication MUST be in the original container. The student has the permission of the parent/guardian to bring the medication to school. If the medication is not picked up at the end of the school year by a parent/guardian, the medication will be destroyed. No medication is kept from school year to school year.

I release school personnel from liability should administering this medication result in an adverse reaction. I give permission for the school nurse to communicate with the student's teacher, physician and necessary school staff about my child's health condition and the action of the medicine. I request this medicine be given on field trips as prescribed. I have read and understand the above.

Parent/Guardian Signature _____ Date _____

Tim Wilson
Principal

Holly Morgan
Assistant Principal

Carla Brege
Secretary

Candas DeHoff
Treasurer