South Bend Community School Corporation
Special Education Services
215 S. St. Joseph St, South Bend, IN 46601
Ph: 574.283.8130 Fax: 574.283.810

Permission For Prescription Medication

Student: _____ SBCSC ID#: _____ STN#: _____

DOB: _____School: _____ Physician: _____
(please print)

Physician's Authorization For Medication

The above named student requires the administration of a prescription medication during school hours. This medication should be administered as follows:

Medication	**Dosage**	**Time**	**Dates To Be Administered**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____
Date Physician Signature

Parent Authorization For Medication

I _____, parent/guardian of _____
(Please print parent/guardian name) (Please print student name)

do hereby authorize school personnel to administer medication to the above mentioned student during school hours in accordance with the physician's written instructions.

I understand that medication can only be administered as defined in the Student Medication Procedure of the South Bend Community School Corporation. Medication must be in the original prescription bottle.

_____ _____
Date Signature of Parent/Guardian