

Request for Permission to Carry Medication/Inhaler During Attendance in School and at School Activities

Student's Name (Please print)

Date of Birth

Grade

This is to certify that the student named above has a medical condition that may require the immediate administration of

Name of medication

Please allow this student to have this medication in his or her possession while attending school and school events.

Signature of Physician/Provider

Date

I understand that according to Wawasee Community School Corporation policy, all medications are to be kept in the nurse's office unless there is a written statement from my physician stating that I may need to use the medication immediately. Since my physician had signed the above form, I understand that I will be permitted to carry this medication with me. I will use it only when needed, and only as directed, and will not allow anyone else to use or possess it. When this medication is used during school hours, I will immediately notify the nurse so she can assess my health status.

Signature of Student

Date

I am the Parent / Guardian of the student identified above. I authorize Wawasee Community School Corporation to permit this student to possess the medication identified above while attending school and school events in accordance with school policy. I will release school personnel from all liability in the carrying out of this procedure.

Signature of Parent/Guardian

Date

Please return this form to the attention of the school nurse:

School	Milford School	North Webster Elementary	Syracuse Elementary	WHS	WMS
Address	PO Box 548 Milford, IN 46542	5745 N 750 E North Webster, IN 46555	502 W Brooklyn St Syracuse, IN 46567	1 Warrior Path Syracuse, IN 46567	9850 N SR 13 Syracuse, IN 46567
Phone	574.658.9444	574.834.7644	574.457.4484	574.457.3147	574.457.8839
Fax	574.658.3429	574.834.1046	574.457.4486	574.457.4364	574.457.3575