

FLAT ROCK HAWCREEK SCHOOL CORPORATION
HAUSER JR. SR. HIGH SCHOOL/HOPE ELEMENTARY SCHOOL
(HAUSER) 9273 N. SR. 9/ (HOPE) 9575 N. SR. 9
HOPE, INDIANA 47246

I, the parent of _____, give permission to administer the following medications in accordance with the following instructions for dose, interval of dosage, and indications for administration.

NOTE: ALL MEDICATIONS MUST BE PROVIDED, THE SCHOOL DOES NOT STOCK MEDICINES.
ALL MEDICATIONS SHOULD BE PICKED UP AT THE END OF THE SCHOOL YEAR IN ACCORDANCE TO SCHOOL POLICY. (REFER TO THE HANDBOOK)

1. Medication: _____

Dose: _____ Time of Dose: _____

Indications: _____

2. Medication: _____

Dose: _____ Time of Dose: _____

Indications: _____

3. Medication: _____

Dose: _____ Time of Dose: _____

Indications: _____

4. Medication: _____

Dose: _____ Time of Dose: _____

Indications: _____

PARENT SIGNATURE: _____

ADDRESS: _____

PHONE: _____

DATE: _____