CONCORDIA LUTHERAN SCHOOL

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KINDERGARTEN ROUNDUP HEALTH FORMS 2023-2024

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ALL FORMS ARE REQUIRED AND SHOULD BE RETURNED TO THE SCHOOL OFFICE NO LATER THAN THE FIRST DAY OF SCHOOL.

***The only exception is the medication consent and that should be returned only if medication is required for school day use.**

ENGAGING HEARTS AND MINDS

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PHONE: (260) 426-9922 x200 ▪ FAX: (260) 422-6980 ▪ E-MAIL: school@clscubs.org

Concordia Lutheran School

Preschool ▪ Elementary School ▪ Middle School

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Important Information for Kindergarten Entrance 2023-2024

Packet

This packet includes several important forms **you will need to complete and return to the school office before your kindergartener begins their first day of school.** This includes the Physical Exam, Health Questionnaire, CHIRP Consent, Dental Exam, Vision Exam, and a copy of your child's up-to-date immunizations.

About Washing Hands

Now is the time to teach your child the importance of good hand washing. Keeping hands clean is one of the best ways to prevent the spread of infection and illness. Help your child stay healthy by teaching and encouraging good hand washing habits.

Regular Sleep Is Very Important

Regular sleep habits are very important to the health and well-being of your child. A young child needs, on average, 10-12 hours of sleep a night. Establish a regular bedtime. Turn off the TV and videos and read a book before bed.

Physical Exam/Health Questionnaire

All students new to our school are required to have a recent physical signed by their physician along with the "Health Questionnaire" form filled out by the parents/guardians. **These forms must be submitted to the school office no later than the first day of school.**

CHIRP

As required by IC 20-34-4-6, we report immunizations to the State Department of Health each year on all students in grades K, 1 and 6. This report is currently done online through CHIRP (Children and Hoosier Immunization Registry Program) and we will need a consent signed for each child in order to report this information to the state. **This form needs to be submitted to the school office no later than the first day of school.**

About Kindergarten Immunizations

IC 20-34-4-2 requires that **ALL** students have the required immunizations **PRIOR** to, **and on file with, the school before the first day of school.** Those entering Kindergarten must be fully immunized following the ACIP (Advisory Committee on Immunization Practices) and Indiana State Department of Health guidelines. These mandatory vaccinations include DTaP (5), IPV (4), Hepatitis B (3), MMR (2), Varicella (2) and Hepatitis A (2). These minimum doses must be met and they must have been given at the proper minimum age and have the proper

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intervals between each one to be acceptable for the state school requirements. A photocopied record of your child's immunizations from your child's physician must be provided to the school **BEFORE THE FIRST DAY OF SCHOOL,** as proof of the vaccines having been given. Students who will not be receiving immunizations for religious reasons (IC 20-34-3-2), or those who have a medical contraindication (IC 20-34-3-3) to vaccine administration, must have the appropriate exemption forms filed annually with the school office.

It is important that you review your child's immunization records now and obtain these necessary immunizations from your child's physician, the Fort Wayne Allen County Department of Health, or any Super Shot location. Remember to provide the school with documentation of all shots received from infancy through the current date.

Unfortunately, if this is not completed by the first day of school, you will receive a letter excluding your child from school until the immunizations have been obtained and proper paperwork has been filed.

Vision - Required FREE vision MCT Exam for all kindergarteners

IC 20-34-3-12 requires all kindergarten or first grade students to have an MCT vision exam done by either an optometrist or ophthalmologist.

We have chosen kindergarten to be done. **To take advantage of a FREE vision screening for your child, please check the back side of the "Kindergarten Vision Examination" form for a list of local optometrists who have agreed to provide this service at no cost for your kindergarten child for a limited time.**

If you prefer to use your own optometrist or ophthalmologist, please take this form to their office and have them completely fill out after your child's exam. Please understand that if you choose your own, you may have an additional cost to incur. It is important that your child be screened for any vision problems at an early age to detect and correct any abnormalities that may exist. Having an eye professional perform this exam is vital. **This exam needs to be done and submitted to the school office no later than the first day of school.**

Dental

Kindergarten students are required to have the "Dental Examination" form completed prior to their first day of school. But, we encourage all of our students to visit their dentist regularly as it is an important part of our general health and well-being. **This exam form needs to be submitted to the school office no later than the first day of school.**

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Health Screening Information

During the school year, the following health screenings will take place as part of the health services to your child, and fulfillment of the health screening laws of the State of Indiana. Some students will receive referral letters from the school nurse as a result of these screenings.

Hearing Screenings

Hearing screenings will be conducted according to IC 20-34-3-14, on all students in grades **1, 4, 7, and 10** as mandated by the state. We will also check all students new to the school, and any others by special request. The school nurse, or trained volunteers, will conduct this screening. Re-checks will be done at least 2 weeks later on students who have questionable results and referral letters will be sent to those who do not meet the required thresholds on these rechecks. The school nurse will also notify the teachers of those students that referral letters are sent to.

PLEASE COMPLETE AND RETURN ALL REFERRAL FORMS TO THE ATTENTION OF THE SCHOOL NURSE

Vision Screenings

Both far and near vision screening will be conducted according to IC 20-31-3-12 for all students in grades **3, 5, and 8**. We will also check all students by special request. The school nurse, or trained volunteers, will conduct this screening. This Indiana Law also requires that **either K or grade 1** be examined by an eye professional, so we have decided to send all of our kindergarten students for the FREE exam that local eye doctors have offered to us. Re-checks will be done on students who have questionable results and referral letters will be sent to those who do not meet the minimum requirements on these rechecks. The school nurse will also notify the teachers of those students that referral letters are sent to.

PLEASE COMPLETE AND RETURN ALL REFERRAL FORMS TO THE ATTENTION OF THE SCHOOL NURSE

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Medications

We will only administer FDA approved over–the–counter (OTC) and prescription medications prescribed to your child (this does not include any herbal medications or narcotic medications). These medications need to be brought to school by an adult in their original package and accompanied by the medication consent form found on our website or in the school office. Medication brought into school will only be available during school hours. Our school policies are in accordance with IC 20-34-3-18. All medication will be kept in a locked cabinet with the nurse, or trained staff member dispensing according to the package instructions. Students are not to have medication with them at any time. The only exception to this is if your child needs emergency medication (ex. insulin, an inhaler or an epinephrine injection) and the proper paperwork is filled out and on file with the school. (Per Concordia Policy, students in 6-8 grade may self-carry with appropriate documentation on file. Forms may be found in the school office) If needed, this form requires a signature from your child's physician and is only for their EMERGENCY medication. These policies are in place to keep your child and others in the building as safe as they can be during the school day. A reminder that all cough drops are considered OTC medication and need to be kept in the school office for your child's use. Please read our full medication policy on the reverse side of the "Medication Consent" form.

Please understand that NO medication can be sent home with your child.

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RETURN TO SCHOOL BEFORE 1ST DAY OF SCHOOL

PHYSICIAN CERTIFICATE OF EXAMINATION FORM

Must be completed by child's physician

Name_____ Date of Birth____/____/____

Allergies_____

Current Medications: (list name, dosage, and time)

1._____Dosage_____Time_____

2._____Dosage_____Time_____

3._____Dosage_____Time_____

Height_____ **Weight**_____ **B/P**_____ **Pulse** _____

Eyes _____

Ears _____

Nose _____

Throat_____

Chest/Lungs _____

Heart _____

Abdomen _____

Hernia_____

Extremities _____

Musculoskeletal _____

Neurological _____

Skin_____

Lab Work *(if indicated)*

Hematocrit _____

Hemoglobin _____

Lead Level _____

Sickle Cell _____

Urinalysis _____

Other_____

Tuberculin Test *(if indicated)*

Type of test _____

Date _____

Results _____

Is this student physically fit to participate in all physical education programs?

Yes_____ No_____ If no, please explain_____

Please list any conditions that should be considered in planning this child's school day:

_____

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Student Name _____ **Grade** _____

IMMUNIZATION HISTORY

PLEASE ATTACH A COPY OF THE CHILD'S FULL IMMUNIZATION RECORD

All Kindergarten students must have an immunization record in the school office *before the first day of school*. This student MAY NOT attend Kindergarten without a record of having received the required immunizations listed below or unless a medical OR religious exemption form has been filed with the school office.

Required vaccinations are as follows:

Kindergarten –5th Grades

DTaP (5) IPV (4) Hepatitis B (3) MMR (2) Varicella (2) Hepatitis A (2)

6th - 8th Grades

Previous listed plus additional Tdap (1) and MCV4 (1)

********These are the minimum doses that are necessary. All minimum ages and intervals for each vaccination as specified in the CDC guidelines must be followed to be considered valid in the State of Indiana.********

_____

Printed/Stamped Name of Physician Completing this Form

_____ _____

Physician's Signature Date

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RETURN TO SCHOOL BEFORE 1ST DAY OF SCHOOL

HEALTH QUESTIONNAIRE

(Parent/Guardian to complete)

Student_____ Grade_____ Date of Birth___/___/___

Address_____ Phone Number_____

Father's Name_____ Mother's Name_____

Student lives with_____

Health History

Check all that apply to your child

- ❑ ADD/ADHD (circle)
- ❑ Allergy *
  - ❑ Seasonal _____
  - ❑ Food _____
  - ❑ Other _____
- ❑ Asthma *
- ❑ Chickenpox
- ❑ Diabetes *
- ❑ Chronic Ear Infections
- ❑ Emotional Disorder
- ❑ GI/GU Issues
- ❑ Hearing Impairment
- ❑ Hepatitis
- ❑ Measles/Mumps/Rubella
- ❑ Mononucleosis
- ❑ Physical Handicaps
- ❑ Pneumonia
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Seizures *
- ❑ Tuberculosis
- ❑ Vision Impairment
- ❑ Whooping Cough
- ❑ Other _____
- ❑ Other _____
- ❑ Other _____
- ❑ Other _____

**Please note these diagnoses may require a completed action plan form.*

Any checks made above, please give explanations and dates of diagnosis:

_____

_____

Has your child had an infectious/communicable disease other than those listed above? Please explain, giving relevant dates:_____

_____

Please list Allergies _____

Does your child need to use an EPI-PEN due to allergic reactions? _____

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HEALTH QUESTIONNAIRE (Continued)

Please list any of the following with the month/year:

Severe Illnesses: _____

Severe Injuries: (head injury, fractures, etc.):_____

Diagnostic Procedures: _____

Hospitalizations: _____

Surgical Procedures:_____

Is there any other information about your child's health status that you think the school should know which may be relevant to your child's health and safety or the health and safety of others in the school
environment?_____
_____

Please list any conditions that should be considered in planning your child's school day:

_____
_____

Physician's Name:_____ Phone_____

Dentist's Name:_____ Phone_____

Eye Doctor's Name_____ Phone_____

To the best of my knowledge the above information is complete and accurate. I acknowledge that I have a continuing obligation to inform the school of any changes in my child's health status that are relevant to the information requested by this form.

_____ _____

Parent/Guardian Signature Date

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RETURN TO SCHOOL BEFORE 1ST DAY OF SCHOOL

KINDERGARTEN MCT VISION EXAMINATION

STUDENT'S NAME_____Birthdate_____

ALL AREAS must be filled out to be considered a complete exam by the State of Indiana.

EXAMINER'S REPORT

VISUAL ACUITY - Near and Far must both be done for this exam.

	NEAR	FAR
Right Eye	_____	_____
Left Eye	_____	_____
Both	_____	_____

REFRACTIVE EYE EXAM **PASS** **FAIL**

OCULAR HEALTH (Both Internal and External) **PASS** **FAIL**

EYE BINOCULAR COORDINATION EXAM **PASS** **FAIL**

Has the parent/guardian been advised of any abnormality? YES NONE

Has the child been prescribed eyeglasses at this time? YES NO

Additional remarks or information which you feel might be of assistance to the school in promoting good vision health for this student:

_____

_____

Examining Eye Doctor's Signature _____Date _____

Stamped/Printed Name, Address and Phone Number of Examining Eye Doctor:

_____

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2023-2024
FREE Kindergarten MCT Vision Screening

The following Optometrists have volunteered to provide **FREE** kindergarten screenings in their offices. I encourage you all to take advantage of this rare FREE preventative health opportunity offered to families in the Allen County Non Public School Association (ACNPSA).

It is necessary to follow the guidelines below in order to ensure a free, professional vision screening.

1. Call one of the following offices and identify yourself and the non-public school your child will be attending.
2. **CALL for an appointment no later than JULY 1** and tell them that your appointment is for kindergarten screening.
3. Be sure to take this kindergarten vision screening report form with you for the optometrist to complete.

Dr. Thomas Baker 749-0407
1318 Minnich Rd. New Haven, IN

Dr. Steven Bennett 490-1060
1850 East Dupont Rd. Fort Wayne, IN

Dr. Aileen Heaston 489-3996
10301 Dawson's Creek Blvd. Suite A Ft. Wayne, IN

Hockemeyer Family Eye Care:
Dr. Troy Hockemeyer 493-1505
Dr. Andrew Hoffman
1010 Boulder Ridge Trail New Haven, IN

Dr. Thomas Zachman 432-1231
7625 W. Jefferson Blvd. Ft Wayne, IN

***We are most appreciative to the above optometrists for their services to the Allen County Non-Public Schools! At the time of your child's appointment, **PLEASE** give them a word of thanks for taking time out of their practice to give back to our community.

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RETURN TO SCHOOL BEFORE 1ST DAY OF SCHOOL

CERTIFICATE OF DENTAL EXAMINATION

Student's Name_____
(Last) (First) (M.I.)

Date of Birth ____/____/____ Enrolling in Grade_____

This form is to be completed by the Child's Dentist.

DENTAL EXAMINATION

Code: No Defect = 0 Defect = Note Condition

Teeth

1. Cavities_____
2. Malocclusion_____
3. Soft Tissue_____
4. Oral Hygiene_____
5. Fluoride_____
6. Sealant_____

PRESENT STATUS

Does this child presently have any tooth decay or other dental defects which may reduce his/her efficiency or prevent him/her from receiving the full benefit of his/her schoolwork? If yes, please explain_____
_____

Further Recommendations

_____
_____

_____ _____
Print/Stamp Dentist's Name Signature

_____
Date

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RELIGIOUS EXEMPTION FOR IMMUNIZATIONS

Reference Indiana Code Section 20-34-3-2

Student's Name _____ Date of Birth ____/____/____

I have been informed of the immunization requirements stated in the Indiana Code.

I understand that all the required immunizations may be obtained through the Allen County Department of Health, free of charge.

Allen County Department of Health
Immunization Clinic Phone Number 260-449-7504

I understand that for the safety of my student, he/she will be dismissed from class in the event of an epidemic involving a disease that he/she has not been vaccinated against.

Understanding all of the above, I wish to document my objection to my student being immunized against the following diseases:

□ Hepatitis A □ Hepatitis B □ DTap □ Polio □ MMR □ Varicella □ Meningitis

And for the following **religious** reasons *(please be specific)*

_____

_____

I understand that I must file a formal objection annually, in lieu of presenting documentation of immunizations received.

_____ _____ _____

Printed name of Parent/Guardian Signature of Parent/Guardian Date

This signed and dated form must be returned to the school office by the first day of school.

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VACCINE MEDICAL EXEMPTION

State Form 54648 (4-11) Indiana State Department of Health, Immunization Division

INSTRUCTIONS

1. This form for any child in grades K – 12 who is unable to receive a vaccine required for school entry due to a medical contraindication.

2. Complete and sign form. Submitted to school as proof of exemption from required immunization.

Patient Name _____ Date of Birth *(month/day/year)* _____

Parent/Guardian Name _____ Relationship _____

Street Address _____

City _____ ZIP Code _____ Telephone Number _____

General Contraindications to All Vaccines (*Vaccine(s) should **not** be given.*)

Severe allergic reaction (e.g., anaphylaxis) after a previous vaccine dose or to a vaccine component

□ Hepatitis B (Hep B)	□ Inactivated poliovirus (IPV)	□ Meningococcal, conjugate (MCV4) or Meningococcal, polysaccharide (MPSV4)
□ Diphtheria, tetanus, pertussis (DTaP, Tdap)	□ Measles, mumps, rubella (MMR)	
□ Tetanus, diphtheria (DT, Td)	□ Varicella (Var)	

Which vaccine or vaccine component caused reaction?_____

Type of Clinical Reaction & Date *(month, day year)* _____

Vaccine Specific Contraindications *(Vaccine should **not** be given.)*

DTaP or Tdap	□ Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within seven (7) days of administration of previous dose of DTP or DTaP
MMR	□ Pregnancy Estimated Date of Confinement: _____ *(month, day, year)* □ Known severe immunodeficiency (e.g., hematologic and solid tumors; receiving chemotherapy; congenital immunodeficiency; long term immunosuppressive therapy; or patients with HIV infection who are severely immunocompromised)
Varicella	□ Pregnancy Estimated Date of Confinement: _____ *(month, day, year)* □ Substantial suppression of cellular immunity

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Vaccine Specific Precautions (*Vaccine may be given or held depending on clinical situation.*)

DTaP	□ Guillan-Barre syndrome (BGS) within six (6) weeks after previous dose of tetanus-containing vaccine. □ History of Arthus-type hypersensitivity reaction following a previous dose of tetanus and/or diphtheria toxoid-containing vaccine: defer vaccination until at least ten (10) years have elapsed since the previous dose. □ Progressive or unstable neurological disorder, uncontrolled seizures or progressive encephalopathy: defer vaccination with DTaP or Tdap until after a treatment regimen has been established and the condition has stabilized.
DTaP or Tdap	□ Temperature of >= 105F within forty-eight (48) hours after vaccination with previous dose of DTP/DTaP □ Collapse and shock-like state (i.e. hypotonic hyporesponsive episode) within forty-eight(48) hours after previous dose of DTP/DTaP □ Seizure or convulsion within three (3) days after receiving a previous dose of DTP/DTaP □ Persistent, inconsolable crying lasting three (3) or more hours within forty-eight (48) hours after previous dose of DTP/DTaP
MMR	□ Recent (within eleven (11) months) receipt of anti-body containing blood product (interval depends on product) □ History of thrombocytopenia or thrombocytopenia purpura
Varicella	□ Recent (within eleven (11) months) receipt of anti-body containing blood product (interval depends on product) □ Receipt of specific antivirals (i.e. acyclovir, famciclovir, or valacyclovir) twenty-four (24) hours before vaccination; if possible, delay resumption of these antiviral drugs for fourteen (14) days after vaccination.

Other Medical Contraindication (*Must list vaccine(s) and contraindications individually)*

Vaccine	**Specific Contraindication**

Please indicate the duration of the medical exemption, and if and when the vaccine can be safely administered.

(Exemption can last for a maximum of one (1) year, and a new form must be completed annually if medical exemption still applies.)

□ Medical exemption is permanent, and will apply for one (1) year from today's date.

□ Medical exemption is temporary (<1 year), and resolution is anticipated by ____/____/____

□ Medical exemption is pregnancy, and Estimated Date of Confinement (EDC) is ____/____/____

Physician Name _____ Physician License Number _____

Office Address _____ Telephone _____

Physician Signature _____ Date *(month, day year)* _____

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January 2023

Dear Parents,

Enclosed is a consent form for your child's immunizations to be entered in CHIRP (Child and Hoosiers Immunization Registry Program). CHIRP is the database of children's records when your child has immunizations administered at the Board of Health or Super Shot. Some physicians' offices also input data to CHIRP as well. Your child's immunizations may already be entered into CHIRP, but you will still need to complete the enclosed form. A consent form is needed for each child.

The Indiana Department of Education is requiring all student immunizations to be entered into CHIRP starting with the 2010-2011 school year. Student immunizations have always been reported to the Indiana Department of Education/Health, but in a numerical report that stated the number of students complete or incomplete. All immunizations have been entered for this year's current Kindergarten, 1st, and 6th grade students. In an effort to be efficient with this process we are beginning the entry process for those students who will be enrolled in Kindergarten for the 2023-2024 school year.

Please complete the form and return with the other Health Forms in the Kindergarten packet.

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RETURN TO SCHOOL BEFORE 1ST DAY OF SCHOOL

CHIRP Consent Form for Release of Immunization Record

The Indiana State Department of Health maintains an electronic immunization registry entitled Children and Hoosiers Immunization Registry Program (CHIRP). CHIRP allows all health care providers within the state of Indiana to enter and view immunization data with this method of electronic documentation. CHIRP ensures that the most up-to-date record of immunizations is available to all health care providers. The Indiana Department of Education mandates that all schools within the state of Indiana utilize CHIRP to document annual immunization reports. We are required to submit these immunization reports to maintain our accreditation. We need your consent via this form to add your child to our school data. The Indiana Department of Education's attorney Dana Long, collaborating with the Indiana State Department of Health, has prepared the consent attached to this document.

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

_____ I hereby consent to the release of such information.

_____ I decline the release of such information.

I, _____ as a parent/legal guardian to the below stated child, give Concordia Lutheran Elementary School permission to release in addition to immunization data, the following information concerning my child to the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

_____ _____
Signature Date

_____ _____
Printed Name of Parent(s)/Guardian(s) Address

_____ _____
City, State and Zip Code Printed Legal Name of Child

_____ _____
Birthdate of Child Grade of Child

(rev ACNPSA 1/23)

ENGAGING HEARTS AND MINDS

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CONCORDIA LUTHERAN SCHOOL

PRESCHOOL ▪ ELEMENTARY SCHOOL ▪ MIDDLE SCHOOL

A Ministry of Concordia Lutheran Church

STUDENT MEDICATION INFORMATION AND CONSENT FORM

I have read and understand the medication policies as indicated on the reverse side.

Prescription Medication(s)

Please administer to my child (printed name) _____, the medication as prescribed below by my child's healthcare provider. The label affixed to the medication bottle/package will meet the requirement for the physician's written order.

AND / OR

Over-The-Counter Medication(s)

Please administer to my child (printed name) _____, the medication as described below.

REMINDER: Prescription and over-the-counter medications must be kept in the original container with the pharmacy or brand label affixed. Medications will only be given as either prescribed by the practitioner or the FDA instructions that are found on the OTC medication label.

NO MODIFICATIONS OF DOSAGE OR FREQUENCY WITHOUT THE WRITTEN CONSENT BY THE CHILD'S HEALTHCARE PROVIDER.

Medication Name	Dosage (mg &/or # of tabs)	Time to Be Given	Date Medication To Be Discontinued	Reason for Medication	Precautions / Side Effects
Example: Pepcid	10 mg	12 noon	8/15	Acid Reflux	Dry Mouth
1.					
2.					
3.					

_____ _____

Parent/Guardian Signature Date

FULL MEDICATION POLICY ON REVERSE SIDE

(revised ACNPSA 1/23)

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MEDICATION POLICIES AND
WRITTEN CONSENT FOR ADMINISTRATION OF MEDICATION

In order to protect the health and welfare of the students and school staff alike, Indiana laws require that parents/guardians consent, in writing, to the administration of medication. In order for the school nurse, volunteer school nurse, or a staff member to administer medications to your student, the medication form on the reverse side must be completed and signed. Please read carefully the school policies regarding medication administration during school hours.

The day-to-day health needs of the students are cared for by the school office personnel. We have a volunteer nurse who assists us with immunizations, vision, and hearing screenings, but a school nurse is not on-site during school hours. As such we are not able to provide the same healthcare as a registered nurse.

1. The school **must have on record a written prescription order from the prescribing physician/practitioner and written consent** from the parent/guardian for prescription medications. There must be a written consent from the parent/guardian for Over-the-Counter (OTC) medications before they will be administered to a student at school. (NOTE: The label on the prescription bottle/package will meet the requirement for physician's written order.)
2. Medications prescribed and/or OTC meds should be kept in the original container with the pharmacy or brand label affixed. The label must include the following: Student's name, name of medication, dosage of medication, and prescribing physician/ practitioner (if applicable).
3. Herbal and narcotic medications will not be given at school.
4. Medication brought to the school must be checked in at the office and kept in a locked cabinet.
5. Bring in only **enough prescription medication for one week** to accommodate the dose amounts for the established time frame, and only **enough OTC medication to cover one week** of doses.
6. The parent/guardian shall accept the legal responsibility for the safe arrival of his/her child's medication to the school. Medication (OTC and/or prescribed) need to be provided and brought in **by the parent/guardian, not the student**.
7. The school nurse/assigned staff member must be aware of the purpose for which the student is receiving the medication.
8. In specific cases, the school nurse/assigned staff member may require the parent/guardian to come to the school to administer the medication.
9. No school employee, other than the school nurse, will give injections, unless appropriate training has been given.
10. All prescribed medication will be administered strictly in accordance with the written order of the physician/practitioner. The dosage may be changed only if the school is provided with the written order of the physician/practitioner authorizing the change. The school secretary/staff cannot take a physician order over the phone.
11. Over-the-Counter medication will not be administered in any manner inconsistent with the instructions on the brand label, unless the school receives a written order of a physician/practitioner authorizing such administration.
12. Self administration of medication will be determined by student age and ability to do so safely. Per Concordia Policy, students in 6-8 grade may self-carry with appropriate documentation on file. Administration/staff will reserve the right to request a student medication administration be supervised, even if the student administers their own medication at home.

IC 20-34-3-18 Indiana State Code reads that a school corporation MAY NOT send home with a student medication that is possessed by a school for administration during school hours or at school functions. Medication that is possessed by a school for administration during school hours or at school functions for a student in grades kindergarten through grade 8 may be released only to:

> The student's parent/guardian OR an individual who is at least 18 years of age **and**, designated, **in writing,** by the student's parent/guardian to receive the medication. (reviewed ACNPSA 1/23)

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