Penn-Harris-Madison School Corporation

MEDICATION SELF ADMINISTRATION(Carry on Student)
FOR EMERGENCY MEDICATIONS ONLY

Student: ____

School: ______________________________ **Grade :** ______________

TO BE COMPLETED BY PHYSICIAN/PRACTITIONER:

My patient _______________________________________ has been instructed in the proper use of:

Medication Name: ____

Dosage: __________________________________Time: ________________________

Precautions/ Side Effects: ____

Termination Date of Medication: ____

Physician/Practitioner Signature: ____

Phone: __________________________________ Date: ________________________

TO BE COMPLETED BY PARENT/GUARDIAN:
I permit my child to carry the above named medication as ordered by his/her physician/practitioner. I understand that sharing medication with other students will result in disciplinary action. I also give my consent for the school nurse to communicate with the supervising physician and to counsel with school personnel regarding the possible effects of the above medication.

Parent/Guardian Signature: ____ Date:_____________

TO BE COMPLETED BY STUDENT:
I understand the purpose, appropriate method, and frequency of use of the above named medication. I understand that sharing medication with other students is potentially dangerous and will result in disciplinary action.

Student Signature: ____ Date: ____________

RED AUTHORIZATION LABEL NEEDS TO BE ATTACHED TO MEDICATION PER HEALTH CARE STAFF BEFORE STUDENT IS ALLOWED TO CARRY MEDICATION INDEPENDENTLY.

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