Penn-Harris-Madison School Corporation
AUTHORIZATION TO ADMINISTER MEDICATION

Student Name_____ **School**_____ **Grade**_____

***To be completed by PARENT**

MEDICATION NAME_____

DOSAGE_____ **TIME**_____

Termination date of Medication_____

I request that my child (the above named pupil) be assisted in taking this medication at school by authorized personnel, and will comply with the policies and procedures of P-H-M. I give my consent for the school nurse to communicate with the supervising physician and to counsel with the school personnel regarding the possible effects of the medication.

***Medication must be in the original container and brought to school by an adult!**

PARENT/GUARDIAN SIGNATURE_____

DATE_____

***To be completed by the PHYSICIAN/PRACTITIONER for PRESCRIPTION/MAINTENANCE medication:**

MEDICATION NAME_____

DOSAGE:_____ **TIME:**_____

Termination date of medication:_____

PRECAUTIONS/SIDE EFFECTS:_____

PHYSICIAN/PRACTITIONER SIGNATURE:_____

PHYSICIAN/PRACTITIONER NAME (PRINTED)_____

DATE:_____

Updated 5-6-11 for PHS
SY 2015-2016

I authorize my student to bring home any unused medication at the end of the school year

Parent/Guardian Signature_____ **Date**_____