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 SY 2015-2016

***I AUTHORIZE THE HEALTHCARE STAFF TO DISPOSE OF ANY UNUSED MEDICATION AT THE END OF THE CURRENT SCHOOL YEAR.**

Parent/Guardian Signature______________________Date______________________