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: _____

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

Parent/Guardian Signature:_____Date:_____

Updated 5-6-14