**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 Penn High 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 my student to bring home any un-used medication at the end of the school year

**Parent/Guardian Signature: ______________________________________Date:_______________**

Updated 5-6-14 for PHS