

# 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.**