Penn-Harris-Madison School Corporation

MEDICATION SELF ADMINISTRATION (Carry on Student)
FOR EMERGENCY MEDICATION ONLY

Student Name: _____

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 side effects of the above medication.

Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY STUDENT

I understand the purpose, appropriate method, and frequency 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: _____

FOR OFFICE USE ONLY

A RED AUTHORIZATION LABEL NEEDS TO BE ATTACHED TO MEDICATION BY HEALTH CARE STAFF BEFORE STUDENT IS ALLOWED TO CARRY MEDICATION INDEPENDENTLY.