PORTER TOWNSHIP SCHOOLS
HEALTH SERVICES

Heather Lint, BSN, RN
Boone Grove High School

Kindra Hamady, LPN
Boone Grove Elem/Middle School

Tracy Steinhilber, CNA
Porter Lakes Elementary

Student Name: _____ DOB: _____ Teacher: _____

Medication Name: _____ Dose: _____
Reason for Medication: _____

Form of Medication: Tablet_____ Capsule _____ Inhaler _____ Topical_____ Injection _____
Start Date: _____ Provide through school year___YES Other STOP DATE:_____

Instructions for administration of medication by school staff: _____
_____
Restrictions and/or side effects of medication: _____
Special storage requirements:

This student is **capable & responsible** for **self-administration** of this medication:
SELF-ADMINISTRATION: Yes _____ Supervised _____ Un-supervised _____ No _____
SELF CARRY (emergency meds only): YES ____ YES PLUS stock for Health Office _____ NO:____

Physician's Signature: _____ Date: _____

Address: _____

Phone: _____ Fax: _____

To be completed by parent/guardian:
I give permission for (name of student) _____ to receive the above prescription medication at school according to standard school policy. Prescription medications must be in its original container.

Parent/Guardian: _____ Date: _____

PORTER LAKES ELEMENTARY
208 S. 725 W., Hebron, IN 46341 (219) 988-2727
FAX: (219) 988-2728

BOONE GROVE ELEMENTARY & MIDDLE SCHOOL
325 W. 550 S. Boone Grove, IN 46302
FAX: (219) 476-4376

BOOE GROVE HIGH SCHOOL
260 S. 500 W. Valparaiso, IN 46385
FAX: (219) 988-4431