HEALTHY CHILDREN LEARN BETTER

PORTER TOWNSHIP SCHOOLS
HEALTH SERVICES
AUTHORIZATION TO ADMINISTER MEDICATION

STUDENT NAME: _____

I authorize the designee of the school to administer the following medication:

Medication Name: _____

Amount: _____

Time: _____

Reason for Administration: _____

Duration: _____

Parent/Guardian Signature: _____

Address: _____

Phone: _____ Date: _____

_____ I will pick up the medication by the last day of school.

_____ Please send the medication home with my child on the last day of school.

_____

Signature: Parent/Guardian