

# PORTER TOWNSHIP SCHOOLS HEALTH SERVICES

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STUDENT NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_

My child may receive the following medications administered from the Nurse's office, ***IF AVAILABLE***,

\_\_\_\_\_ Generic Tylenol, 500 mg, dose per weight \_\_\_\_\_ Ibuprofen, 200 mg, dose per weight  
 \_\_\_\_\_ Cough Drops \_\_\_\_\_ Visine eye drops \_\_\_\_\_ Tums/Roloids

***Other medication/Prescription or over the counter\*\*supplied by parent to be given at school***

Medication \_\_\_\_\_ Dose \_\_\_\_\_  
 Time \_\_\_\_\_ Reason \_\_\_\_\_ Duration \_\_\_\_\_

Medication \_\_\_\_\_ Dose \_\_\_\_\_  
 Time \_\_\_\_\_ Reason \_\_\_\_\_ Duration \_\_\_\_\_

\*If more than 2 medications, use the bottom of this form.

**Permission to use/carry inhaler**

- My child has been instructed in the proper use of his/her inhaler
- Inhaler can be carried by student. (A written order from the Physician is needed) The school is not responsible for safeguarding the students inhaler at school
- Inhaler needs to remain in the nurse's office

**\*\*No medication, prescription or over-the-counter will be given to a student without this or other written authorization from the Doctor and/or Parent/Guardian. The pharmacy label on the prescription bottle serves as written authorization by the Doctor, and this signed notice serves as written authorization by the Parent/Guardian. All medication must be in its original bottle and clearly labeled. *The nurse cannot dispense unidentified medication in a plastic bag or unmarked container.* *This authorization form is valid for the current school year only.***

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Medication \_\_\_\_\_ Dose \_\_\_\_\_  
 Time \_\_\_\_\_ Reason \_\_\_\_\_ Duration \_\_\_\_\_

Medication \_\_\_\_\_ Dose \_\_\_\_\_  
 Time \_\_\_\_\_ Reason \_\_\_\_\_ Duration \_\_\_\_\_

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 Time \_\_\_\_\_ Reason \_\_\_\_\_ Duration \_\_\_\_\_