PORTER TOWNSHIP SCHOOLS
HEALTH SERVICES

Student Name:____DOB:______________Grade:_____________

Medication Name:____Dose:______________________

Reason for Medication:____

Form of Medication: Tablet_____ Capsule_____ Inhaler_____ Topical_____ Injection_____ Other_____

Start Date:_________ Provide through school year: _____YES Other STOP DATE:________________________

Instructions for administration of medication by school staff:____

____

Restrictions/side effects/special storage requirements____

EMERGENCY MEDICATIONS ONLY:

The student is responsible and capable of self-administration:

Yes, Unsupervised______ Yes, With Supervision______ No______

SELF CARRY (emergency meds only):

Yes______ YES, PLUS Health Office stock_____________ No______

Physician/NP Name:____Date:_____________
Phone Number:____
Physician/NP Signature:____

To be completed by Parent/Guardian:

I give permission for (name of student)________________________to receive the above prescription medication at school according to policy. Prescription medications must be in the **original container**.

Parent/Guardian:____Date:____________

PORTER LAKES ELEMENTARY
208 S. 725 W., Hebron, IN 46341 (219) 306-8076
FAX: (219) 306-8636

BOONE GROVE ELEMENTARY & MIDDLE SCHOOL
325 W. 550 S., Boone Grove, IN 46302 (219) 306-8663
FAX: (219) 476-4376

BOONE GROVE HIGH SCHOOL
260 S. 500 W., Valparaiso, IN 46385 (219) 476-3455
FAX: (219) 306-8659