PHYSICIAN AUTHORIZATION FOR STUDENT MEDICATION

Name of Student **Date of Birth**

Diagnosis _____ **Any Known Allergies**

This authorization is valid until the start of the next school year unless ordered to be discontinued sooner.

Date to start _____ ***Date to discontinue*** _____

Name of Medication _____ **Dose** _____
amount to be given (in metric mass, i.e. mg)

Specific time _____ **Frequency** _____

Route of medication
- ☐ Oral
- ☐ Injectable – specify:
  - ☐ *intramuscular* ☐ *subcutaneous*
- ☐ Rectal
- ☐ Topical
- ☐ Inhaled
- ☐ Inhaled using Aerochamber
- ☐ Inhaled using Nebulizer
- ☐ Nasal
- ☐ Other (specify) _____

Location of medication
- ☐ Stored in health room
- ☐ Carried on person ***(as allowed by School Board policy, i.e., epinephrine, inhaler, pancreatic enzymes.)***
- ☐ Other (Specify) _____

Special Instructions _____

Specify instructions for emergency medication repeat dosing _____

Desired action of medication _____

Symptoms of adverse reaction to medication _____

Does the student take the above medication or any other medications at home? ☐ Yes ☐ No

If Yes, Medication _____ Dose _____ Frequency _____

Other medication _____ Dose _____ Frequency _____

Physician Authorization

- If location of medication is indicated above as carried on person, the student has been trained and has my permission to self-administer the prescribed medication if the school nurse determines it is safe and appropriate.
- The parent knows of this request and has agreed to provide the supplies needed for the above medication.
- Should the student manifest any of the above symptoms that may be caused by the medication, I understand that the parent will be contacted and the School Health directives relating to emergency care will be followed.

_____ _____ _____
Physician's Name (Print) *Physician's Signature* *Date*

_____ _____ _____
License Number (to prescribe in State of Florida) *Telephone Number* *Fax Number*

Parent/Guardian Acknowledgements and Consents

I acknowledge that I have received a copy, I have reviewed, and I understand the Parent/Guardian responsibilities detailed on page 2 of this Physician Authorization. Parent/Guardian may retain page 2 for their own records.

I give permission:

- To the onsite/contract healthcare personnel to share information with appropriate school staff relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
- To the school/contract nurse to contact the above health care provider for information relevant to the prescribed medication as he/she determines appropriate for my child's health and safety.
- For my child (named above) to receive medication administered by the onsite healthcare personnel or trained school staff member designated by the principal. This medication has been prescribed by a licensed health care provider. I hereby release the School District and its agents and employees as well as the School Health Program from any and all liability that may result from my child taking the medication.

_____ _____ _____
Parent/Guardian's Name (Print) *Parent/Guardian's Signature* *Date*

_____ _____ _____ _____
Home Phone *Work Number* *Cell Phone* *Other Contact Number*