

THE SCHOOL BOARD OF HARDEE COUNTY

**MEDICATION/TREATMENT AUTHORIZATION FORM**

Student's Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

**The following section is to be completed by the parent or legal guardian:**

I hereby grant permission to the school staff to administer prescribed medication and/or treatment to my child while in school and away from school while participating in official school activities (F.S. 1006.062). **It is my responsibility to notify the school if and when these orders change.** I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication and/or treatment where the person administering such medication and/or treatment acts as a reasonably prudent person under the same or similar circumstances.

Parent/Guardian name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Emergency # \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**List child's allergies** \_\_\_\_\_

**The following section is to be completed by the prescribing physician:**

**(A separate form must be completed for each medication or treatment prescribed)**

The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following medication/treatment, which is necessary to be given at school. I am aware that trained non-medical staff may administer this physician prescribed service.

**This order is to be effective for the school year: 201** \_\_\_ -**201** \_\_\_\_\_

Diagnosis (for this medication/treatment):	
Treatment:	
Name of medication:	Dose:
Instructions:	
Route:	Oral      Topical      Subcutaneous      I.M.      Inhaled      Other
Time medication is given at home: (if applicable)	
Possible side effects:	
Is student authorized to carry and use asthma inhalation medication or EpiPen?	Yes      No
Has student been instructed in the use of asthma inhaler or EpiPen?	Yes      No
Other information:	
Physician Signature:	Date:
Physician Name:	
Physician Address:	Phone:      Fax:
Medication order reviewed by school R.N.:	Date:
Medication stopped by Parent/Guardian: Date:	Parent/Guardian Signature: