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: