THE SCHOOL BOARD OF HARDEE COUNTY

Bob Shayman, Superintendent

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MEDICATION/TREATMENT AUTHORIZATION FORM

- For Administration during School Hours –

Dear Parent/Legal Guardian:

If your child needs to have medication(s) treatment(s) given during the school day, state regulations and school board policy require that you and your doctor provide written permission for administration of both prescribed and over-the-counter medication(s) or treatment(s).

(Medication refers only to those products which have been approved by the "Food and Drug Administration" (FDA) for use as a drug.)

- **Prescribed medications** must arrive in a container with the original, unaltered prescription label attached. **The label must display all legal information required for a pharmacist to dispense a prescription medication such as valid issue and expiration dates, the patient's name, the medication name and dosage instructions, and the doctor's name. The label information must match the physician's order.**
- **Over-the-counter medications** must arrive in the original, unopened store-issued container. Please take the time to label the container with your child's full name and birth date, the date you send the medication to school and the dosage prescribed by the doctor.

- The Medication/Treatment Authorization Form on the reverse side of this document must be completed entirely and accompany any medication (either prescribed or over-the-counter) to be given to your child in school. **Both a parent/legal guardian and the prescribing doctor must sign the form.** Staff will not be able to administer medications to your child without this **written consent.**

- The parent, legal guardian, or an authorized adult must hand carry medications to the school health room. The health room aide upon receipt will verify the quantity or each medication. **Do not send medications to school your child.**

- **The RN at your child's school may need to call the doctor's office for medication/treatment clarification.**

- The parent or legal guardian will need to pick up the medication at the end of the school year or if the medication is discontinued or changed during the school year. If the medication is not picked up, it will be discarded.

Thank you for your cooperation.

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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: