

**HEALTH SERVICES**

**AUTHORIZATION TO ASSIST IN THE ADMINISTRATION OF MEDICATION/TREATMENT**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Teacher/Grade: \_\_\_\_\_

List Known ALLERGIES: \_\_\_\_\_

**NURSING SERVICES AND MEDICATION/TREATMENT ORDER**

*ALL INFORMATION MUST MATCH THE PRESCRIPTION LABEL! All medication must be properly labeled and in original containers. Complete one form for each medication/treatment to be administered. A new form must be completed if the dosage of a medication changes at any time.*

**Nursing services are recommended for the care of this student during the school day.**

*It is necessary for the following medication/treatment to be given in school and during school sponsored activities. I am aware that non-medical personnel may administer this medication/treatment.*

**Name of medication/treatment:** \_\_\_\_\_ **Amount (Dosage):** \_\_\_\_\_

**Time to be given:** \_\_\_\_\_ **Date to start:** \_\_\_\_\_ **Date to end:** \_\_\_\_\_

**Health condition requiring medication:** \_\_\_\_\_

**Possible side effects:** \_\_\_\_\_

**Special instructions:** \_\_\_\_\_

**Physician ordering medication:** \_\_\_\_\_  
(please print)

**Physician address:** \_\_\_\_\_

**Physician's phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Physician's signature:** (required for all medications) \_\_\_\_\_ **Date:** \_\_\_\_\_

**PARENT/GUARDIAN to Complete: Authorization for Health Care Provider and School Nurse to Share Information**

I authorize my child's school nurse to assess my child as regards his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

As the parent or guardian of the student named above, I request that the principal or principal's designee assist in the administration of medication/treatment prescribed for my child.

I understand that under provisions of Florida Statute 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them. I authorize the physician to release information about this condition to school personnel.

\_\_\_\_\_  
**Parent/Guardian Signature**                      **Print Name**                      **Phone Number**                      **Date**

**EMERGENCY MEDICATION (INHALER/EPINEPHRINE)—Florida Statute 1002.20**

*Florida law states a student may carry a metered dose inhaler or epinephrine auto-injector on his/her person and self-administer while in school with approval from his/her parents **and** physician.*

*The above named child may carry and self-administer his/her emergency medication.*

**Parent/Guardian signature:** (required) \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician's Signature:** (required) \_\_\_\_\_ **Date** \_\_\_\_\_