

School Board

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School Health Services
Parental Authorization for Administration of Medication

D
ate _____

Student's
Name _____ Date
of Birth: _____
Last First Middle

Teacher's
Name _____ Grade _____ Room Number _____

As the parent/guardian of the student named above we/I request the principal / principal's designee to administer the medication(s) described below to our/my child at school.

Known Allergies _____

<u>Medication</u>	<u>Amount/Strength</u>	<u>Dose</u>	<u>Time</u>	<u>Purpose of Medication</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Date Medication Begins: _____ Date Medication Ends: _____

Physician's Name _____ Phone Number _____

We/I understand that under the provision of Florida Statute 1006.062 school personnel cannot be held liable for reactions or side effects from the administration of the medication(s). We/I also grant permission for school personnel to contact the physician if there are questions or concerns about the medication(s). We/I have read the attached guidelines and agree to abide by them.

In addition, please list the medications your child takes at home (include dosage and times)

Where does the child go
after school? _____

Please note: early release days may effect administration of medication.

Early release time: _____ Will medication be given? Yes No (Circle)

Parent/Guardian Signature	Home Phone	Work Phone
Parent/Guardian	Home	Work