HEALTH SERVICES

Medication Administration

AUTHORIZATION TO ASSIST IN THE ADMINISTRATION OF MEDICATION/TREATMENT

Student Name: _____ Date of Birth: _____

School: Therapeutic Learning Center Teacher: _____

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 Staff to Share Information

I authorize my child's school staff 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 Director, Director's designee, Therapy, or Teaching Staff assist in the administration of medication/treatment prescribed for my child.

I understand that under provisions of Florida Statue 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 ☐)—

Emergency Medication provided by parent will remain at school School/After-School/Therapy, or other trained staff may administer emergency medication to the above named child.

Parent/Guardian signature: (required) _____ Date: _____

Physician's Signature: (required) _____ Date _____