

Authorization for Medication/Treatment



The following section is to be completed and signed by the PARENT:

A new authorization must be completed at the beginning of each school year or anytime a dosage is changed. All medications and/or treatment, equipment or supplies must be provided by the parent.

Revised 7-23

Child's Name _____				
Last	First	Sex	Grade	Date of Birth
Physician's Name _____		Address _____		Emergency Phone _____
<p>I hereby authorize the above named physician and Polk County Public Schools/Florida Department of Health in Polk County staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand Polk County School District protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed, or electronic.</p> <p>I request that my child be assisted in taking the medication or treatment described below at school by authorized persons as permitted by my physician and me (<i>see below</i>). This medication must be provided during the school day because:</p> <p>___ See order below. OR ___ Other (List reason) _____</p> <p>_____</p>				
Date _____	Parent/Guardian Signature _____	Home phone _____	Emergency phone _____	

The following section is to be completed by the PHYSICIAN: (ONLY ONE medication or treatment per form)

Diagnosis for which medication or treatment is given: _____
Name of medication or treatment: _____
Form: _____
Dose: _____
Route: _____
If medication or treatment is to be given at school, at what time: _____
If medication or treatment is to be given "When needed", describe indications: _____

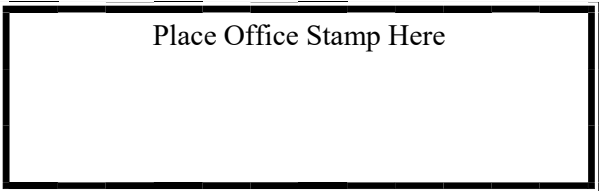
How soon can it be repeated? _____
List significant side effects: _____

Length of time medication/treatment is recommended: _____

Other information:

_____ _____

_____ Date _____ Physician's/Mid-level Practitioner's Signature



Adapted from the American College of Allergists

