Authorization for Medication /Treatment

Revised 4-14

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.

Child's Name _____ (Last / First) ____ (Sex) ____ (Grade) _____ (Date of Birth)

_____ (Physician's Name) _____ (Address) _____ (Emergency Phone)

I hereby authorize the above named physician and Polk County 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.

I request that my child be assisted in taking the medication or treatment described below at school by authorized persons as permitted by me and my physician (*see below*).

_____ (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: _____

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)

Place Office Stamp Here

Adapted from the American College of Allergists