Medical Authorization

The following section is to be completed by the **PARENT/GUARDIAN** for the administration of medication. Medications must be in original containers.

Child's Name: _____ _____ _____
Last First Sex Date of Birth

_____ (____) _____
Physician's Name Address Telephone

I deliver the medicine(s) described below to ***Name of School*** *to be held for use by my child in accordance with the instructions given below. I consent and authorize the person designated by the School to dispense and to supervise my child's self-administering the medicine(s). We/I understand that the School assumes no responsibility for the instructions we/I have provided below, other than to allow my child to self-administer the medicine(s) and we/I assume all risk associated with the child's taking such medicine(s).*

We/I understand that under the provision of Florida Statute 232.46, 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).

_____ (____) _____ (____) _____
Date ***PARENT/GUARDIAN*** Signature Home Phone Emergency Phone

The following is to be completed by the **PHYSICIAN**:

Diagnosis for which medication is given: _____

Name of Medicine _____

Form _____

Dose _____

If medicine is to be given DAILY, at what time? _____

If medicine to be given "WHEN NEEDED," describe indications: _____

How soon can it be repeated? _____

Is child authorized to medicate herself/himself? _____

List significant side effects: _____

Length of time this treatment is recommended: _____

Other information: _____

_____ _____
Date Physician Signature