

## PHYSICIAN and PARENT MEDICATION AUTHORIZATION FORM - General for

## **Administration of Medication During School Hours**

## To Be Completed by Licensed Health Care Provider

Student Name	DOB	Allergies
Medical Diagnosis:	Diagnostic Code:	
Name of medication:		
Time to be given:		/en:
Duration of time child is to receive medication:		
Reactions to monitor for:		
Licensed Health Care Provider's Signature:		
Please print the following information:		
Licensed Health Care Provider's Name:		
Address:		
Telephone No.:		
To be completed by PARENT/GUARDIAN		
I hereby grant permission to the principal or his/her design of the prescribed medication to my child while in school (F.S.232.46). It is my responsibility to notify the school there shall be no liability for civil damages as a result of the administering such medication and/or treatment acts as an accircumstances.	and away from school while partic of if and when these orders chang he administration of such medicate	cipating in official school activities  ge. I understand the law provides that
Parent's Signature:		Date:
Please print parent's name:		
Does this medication need to be provided during		No

 Physician and Parent Medication Authorization Form must be completed for each individually prescribed medication

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