Manatee County School Health Services

MEDICATION AUTHORIZATION FORM

Student's Name	Sex	Date of Birth	Grade

School Name _____ FAX Number _____

This form is to provide medical and parental authorization for medication to be provided during school hours. Both the physician and parent/legal guardian portions of this authorization form must be completed entirely, signed, and returned to the school **before** the medication may be administered. **Over the counter medication such as Tylenol, cough syrup, Benadryl, Advil, and nutritional supplements also need this form filled out completely including the physician section.**

The following section is to be completed by the prescribing physician:

The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following medication which is necessary to be given in school. I am aware that this physician prescribed service may be administered by trained non-medical staff**. NOTE: A separate form must be completed for each medication prescribed or any change.**

Diagnosis for which medication will be required at school:		ICD10 Code:
Name of medication (example: Ritalin)		
Route (Please check one) ☐ Oral ☐ Topical ☐ Subcutaneous ☐ Inhaled ☐ Intramuscular ☐ Other (describe)		
Dosage (number of milligrams)		
Frequency	If medication is to be given at "scheduled times", at what time(s)?	_____
	If medication is to be given "when needed", when would it be indicated and how many times can it be given?	_____
If applicable, is student authorized to carry and use asthma inhalation medication, epinephrine auto-injection, or pancreatic enzyme supplement and self-administer: ☐ YES ☐ NO		
List any significant side effects of the medication:		
Length of time (duration) medication is recommended:		

Physician's Name: _____ Phone #: _____ Fax#: _____
(Please print)

Physician's Address: _____

Physician's Signature: _____ Date: _____

The following section is to be completed by the parent or legal guardian:

I hereby grant permission to the principal (or his/her designee) of my child's school to administer the above prescribed medication to my child while in school and away from school while participating in official school activities (F.S. 1006.062). **It is my responsibility to notify the school if and when these orders change.** I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinary reasonably prudent person would under the same or similar circumstances. I understand the school will not be responsible for monitoring a student's self-medication.

Name: _____ Relationship: _____

Cell Phone # _____ Home Phone # _____ Business Phone # _____

Signature: Parent/Legal Guardian _____ Date: _____

Review/Revised: 5 /25/16