



# 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:		ICD9 Code:
Name of medication (example: Ritalin)		
Route (Please check one) <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Inhaled <input type="checkbox"/> Intramuscular <input type="checkbox"/> 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: <input type="checkbox"/> YES <input type="checkbox"/> NO		
List any significant side effects of the medication:		
Length of time (duration) medication is recommended:		
Physician's Name: _____ (Please print)		Phone #: _____ Fax#: _____
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: \_\_\_\_\_