THE SCHOOL DISTRICT OF HERNANDO COUNTY, FLORIDA

Authorization for Administration of Prescribed Medication/Treatment

Student´s Name _____ Student´s I.D. Number _____ Student´s Date of Birth _____

School _____ School Address _____

AUTHORIZATION TO ADMINISTER PHYSICIAN PRESCRIBED MEDICATION/TREATMENT TO STUDENTS BY AUTHORIZED PERSONNEL:

1. Prescribed medications or treatments can only be administered or performed at school when failure to receive such medication or treatment could jeopardize a student´s health.
2. The Physician Authorization and Legal Guardian Permission segments of this form must be completed and signed prior to the execution of the prescription.
3. This form must be updated every school year. If medication is changed by the physician during the year, a new form must be submitted to the school nurse.

PHYSICIAN'S AUTHORIZATION (***To be completed by the prescribing physician.***) ´

THE ABOVE STUDENT IS UNDER MY MEDICAL SUPERVISION. I HAVE PRESCRIBED THE FOLLOWING MEDICATION AND/OR TREATMENT:

Medication/Treatment: _____

Amount: _____

Specific Procedure: _____

_____

_____

_____

REASON(S) FOR MEDICATION/TREATMENT: _____

_____

_____

_____

POSSIBLE ADVERSE REACTIONS OR COMPLICATIONS OF THE PRESCRIBED MEDICATION/TREATMENT: _____

_____

_____

_____

Allergies: _____

Physician´s Name (Printed): _____ Phone Number: _____

Physician´s Address: _____

Physician´s Signature: _____ Date: _____

LEGAL GUARDIAN PERMISSION ***(To be completed by student's legal guardian.)***

Name: _____ Address: _____

Home Phone: _____ _____

Business Phone: _____ Emergency Phone: _____

I HEREBY REQUEST THAT MY CHILD BE GIVEN THE ABOVE PRESCRIBED MEDICATION AND OR TREATMENT WHILE IN SCHOOL AND AWAY FROM SCHOOL FOR ACTIVITIES. I UNDERSTAND THE LAW PROVIDES THAT THERE SHALL BE NO LIABILITY FOR CIVIL DAMAGES AS A RESULT OF THE ADMINISTRATION OF SUCH MEDICATION AND/OR TREATMENT WHERE THE PERSON ADMINISTERING SUCH MEDICATION AND/OR TREATMENT ACTS AS AN ORDINARILY REASONABLY PRUDENT PERSON WOULD HAVE UNDER THE SAME OR SIMILAR CIRCUMSTANCES.

Signature of Legal Guardian: _____ Date: _____

SO-SS-007 (Front)
February 2009
Reorder from Printing

DISTRIBUTION:
White : School Clinic Yellow : Parent
Pink: Prescribing Physician

Instructions on reverse side.

AUTHORIZATION FOR ADMINISTRATION OF PRESCRIBED MEDICATION AND/OR TREATMENT

Instructions for Completion:

1. The Clinic Aide should complete the top section of the form with the demographic information about the student.

2. The Physician then completes the center section with the prescribing information.

3. The bottom section is to be completed by the parent or legal guardian of the student involved. Parent's signature should be obtained only after the parent has reviewed the information on the form.

4. The original of the completed form should be filed in the student's cumulative records. Copies of the completed form should be distributed as follows:

    a. Clinic Aide
    b. Prescribing Physician
    c. Parent
    d. Any other appropriate individuals

The form should be renewed annually and also any time there is a change in the student's medication and/or procedure.