Alachua County Public Schools

Health Services

Medication/Treatment Authorization Form

Administration of medication/treatments during school hours will occur only when medication schedules cannot be adjusted to provide administration at home by the parent/guardian.

Student's Name:_____ Date of Birth:_____ Grade:_____

School Name:_____ Teacher:_____

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

List child's health conditions and allergies:_____

_____

Name of medicine:_____ Strength:_____

Form:_____ Route:_____ Expiration Date:_____

Amount to be given:_____ Time(s) to be given:_____

Prescribing doctor's name:_____

Illness or condition prescribed for:_____

Dates medicine are to be given:

Start Date:_____ until End of school year unless otherwise indicated here:_____

Prescription medicine **MUST** have original in-date, unaltered prescription label on the bottle; this label will include the child's name, medication, dosage, frequency of administration, doctor's name, pharmacy's name and phone number.

Non-prescription medicine **MUST** be age appropriate and in original in-date (store labeled) container, marked with the student's name. Medication dose cannot exceed dose specified on medication label without a physician's order. No Aspirin, aspirin products and/or naturopathic products will be given without a physician's order.

I hereby grant permission to the school nurse, principal or the trained school-designated staff to assist in the administration of the prescribed medication and/or treatment to my child while in school and away from school while participating in official school activities (F.S.1006.062). I permit Alachua County Public School staff to contact my child's physician and pharmacy in reference to this medication.

I understand the law provides that there shall be no liability 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 under the same or similar circumstances. **I understand it is my responsibility to supply medication refills as described above and treatment supplies when necessary in addition to notifying school personnel of any changes in my child's health condition, medication, doctor orders and/or treatment.**

Parent/Guardian name:_____ Relationship:_____

Home Phone #:_____ Work Phone #:_____ Cell Phone #:_____

Signature:_____ Date:_____

Date	Amount in Bottle	Number of Doses/Inventory	Expiration Date	Initial Receiver	Initial Witness

Signature of Receiver/Initial

Signature of Witness/Initial