Alachua County Public School – Health Services MEDICATION/TREATMENT AUTHORIZATION FORM

Student's Name:		Date of Birth:	Grade:
School Name:			
The following sect	tion is to be completed b	y the parent or legal g	uardian:
List child's health conditions	and allergies:		
Name of medicine:		Expiration date:	
Amount to be given:	Time(s) to be g	given:	
Prescribing doctor's name:			
Illness or condition prescribe	d for:		
Dates medicine are to be give	en: beginning on date:	ending on da	ite:
Prescription medicine MUST will include the child's name pharmacy's name and phone Non-prescription medicine Modication of the student's name. Medication of physician's order. No Aspiri	e, medication, dosage, from number. IUST be in original (stored dose cannot exceed dose)	equency of administration equency of administration and the labeled) container, also specified on medication	on, doctor's name, o marked with the label without a
I hereby grant permission to administration of the prescriaway from school while partial furnish the school with this reto notify the school if and vestaff to contact my child's ph	bed medication and/or the rticipating in official scenedication in the bottles a when these orders change	reatment to my child whool activities (F.S.100 as described above. It is ge . I permit Alachua Co	while in school and 06.062). I agree to my responsibility unty Public School
I understand the law provide such medication and/or tre- treatment acts as an ordinal circumstances	atment where the perso	on administering such	medication and/or
Parent/Guardian name:		Relationship	:
Home Phone #:			
Signature:		Date:	

Form No.: HTH 213.062 – Medication-Treatment Authorization Form

New Date: 11/15/12

Date	Number of doses received	Signature of receiver/ witness
	1	

Form No.: HTH 213.062 – Medication-Treatment Authorization Form New Date: 11/15/12