UNIVERSITY OF
FLORIDA

Department of Pediatrics
Division of Pulmonary Diseases

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Authorization for Medications to be Taken During School Hours

Student's Name: | **DOB**

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to medicate herself/himself as authorized by me and my physician. **I permit school staff to discuss this medication with the UF Pediatric Pulmonary staff or the child's pharmacy.**

Parent Signature: **Date:**

Diagnosis for which medication is given:	Cystic Fibrosis
Name of medication	
Form:	Capsule
Dose:	
Time medication is to be given	Immediately before all meals and snacks
Indications for unscheduled medication	CF
Frequency	Repeat with all food intake except fruits
Is child authorized to self medicate?	No
Significant side effects of medication	None
Length of time this treatment is needed	ongoing

Physician Signature_____ **Date:**_____

Comments:

Failure to take this medication causes malabsorption of food which may cause abdominal pain and excessive gas