Alachua County Public School – Health Services

MEDICATION/TREATMENT AUTHORIZATION FORM

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

School Name: _____

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

List child's health conditions and allergies:_____

_____

Name of medicine:_____ 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: beginning on date: _____ ending on date:_____

Prescription medicine **MUST** have original, 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 in original (store labeled) container, also marked with the student's name. Medication dose cannot exceed dose specified on medication label without a physician's order. No Aspirin or Aspirin products will be given without a physician's order.

I hereby grant permission to the principal or the school-designated person 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 agree to furnish the school with this medication in the bottles as described above. **It is my responsibility to notify the school if and when these orders change**. 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

Parent/Guardian name:_____ Relationship:_____

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

Signature:_____ Date:_____

Date	Number of doses received	Signature of receiver/ witness