

THE SCHOOL BOARD OF ST. LUCIE COUNTY, FLORIDA
PHYSICIAN'S AUTHORIZATION FOR MEDICATION

PART I: (To be completed by physician's Office)

To the Principal of _____ School

Name of Student/Patient _____ DOB _____

In order to keep this child in optimum health and to help maintain maximum school performance and attendance, it is necessary the medication listed below be given during school hours. (No injections are given except in extreme emergencies such as allergic reaction to insect stings.) **ONE MEDICATION PER FORM PLEASE**

MEDICATION NAME: _____ **DOSAGE:** _____

FORM: Pill/Tab Capsule Liquid Other _____ ICD-9 DX Code _____

SCHEDULE: (how often or what time) _____

PRN ORDERS

IF YOU ARE ORDERING MEDICATION "AS NEEDED", PLEASE SPECIFY UNDER WHAT CONDITIONS THE CHILD IS TO TAKE i.e. pain: _____

ANY SPECIAL INSTRUCTIONS: _____

INHALER/NEBULIZER: Medication Name: _____ # of puffs _____

SCHEDULE: (how often or what time) _____ If you are ordering the

inhaler "as needed", please specify under what conditions: (check all that apply)

SHORTNESS OF BREATH **COUGHING** **WHEEZING** **OTHER** _____

The Student has been trained and has my permission to self-administer the MDI.

CHECK ONE: Student may carry inhaler _____ Inhaler to be kept in clinic _____

Physician Name (Please Print)

Physician Signature

Date

Telephone

PART II: (to be completed by parent/guardian)

I HEREBY GIVE PERMISSION:

- FOR MY CHILD, NAMED ABOVE, TO RECEIVE MEDICATION DURING SCHOOL HOURS. A LICENSED PHYSICIAN HAS PRESCRIBED THIS MEDICATION.
- TO THE SCHOOL NURSE TO SHARE INFORMATION WITH APPROPRIATE SCHOOL STAFF RELEVANT TO THE PRESCRIBED MEDICATION ADMINISTRATION AS HE/SHE DETERMINES APPROPRIATE FOR MY CHILD'S HEALTH AND SAFETY.
- TO THE SCHOOL NURSE TO CONTACT THE ABOVE HEALTH CARE PROVIDER FOR INFORMATION RELEVANT TO THE PRESCRIBED MEDICATION ADMINISTRATION AS HE/SHE DETERMINES APPROPRIATE FOR MY CHILD'S HEALTH AND SAFETY.

Parent/Guardian Signature

Telephone

Date

Part III: (for school use only)

DATE REC'D BY SCHOOL: _____ BY: _____

HEALTH PARAPROFESSIONAL: _____

REVIEWED BY: _____ DATE: _____

APPROVED BY _____ DATE: _____