THE SCHOOL DISTRICT OF HERNANDO COUNTY, FLORIDA

Authorization for Administration of Prescribed Medication/Treatment

Student´s Name ______ Student´s I.D. Number ______ Student´s Date of Birth ______

School ______ School Address ______

AUTHORIZATION TO ADMINISTER PHYSICIAN PRESCRIBED MEDICATION/TREATMENT TO STUDENTS BY AUTHORIZED PERSONNEL:

1. Prescribed medications or treatments can only be administered or performed at school when failure to receive such medication or treatment could jeopardize a student´s health.
2. The Physician Authorization and Legal Guardian Permission segments of this form must be completed and signed prior to the execution of the prescription.
3. This form must be updated every school year. If medication is changed by the physician during the year, a new form must be submitted to the school nurse.

PHYSICIAN'S AUTHORIZATION (*To be completed by the prescribing physician.*) ´

THE ABOVE STUDENT IS UNDER MY MEDICAL SUPERVISION. I HAVE PRESCRIBED THE FOLLOWING MEDICATION AND/OR TREATMENT:

Medication/Treatment: ______

Amount: ______

Specific Procedure: ______

REASON(S) FOR MEDICATION/TREATMENT: ______

POSSIBLE ADVERSE REACTIONS OR COMPLICATIONS OF THE PRESCRIBED MEDICATION/TREATMENT: ______

Allergies: ______

Physician´s Name (Printed): ______ Phone Number: ______

Physician´s Address: ______

Physician´s Signature: ______ Date: ______

LEGAL GUARDIAN PERMISSION (*To be completed by student's legal guardian.*)

Name: ______ Address: ______

Home Phone: ______

Business Phone: ______ Emergency Phone: ______

I HEREBY REQUEST THAT MY CHILD BE GIVEN THE ABOVE PRESCRIBED MEDICATION AND OR TREATMENT WHILE IN SCHOOL AND AWAY FROM SCHOOL FOR ACTIVITIES. I UNDERSTAND THE LAW PROVIDES THAT THERE SHALL BE NO LIABILITY FOR CIVIL DAMAGES 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 HAVE UNDER THE SAME OR SIMILAR CIRCUMSTANCES.

Signature of Legal Guardian: ______ Date: ______

SO-SS-007 (Front)
February 2009
Reorder from Printing

DISTRIBUTION:
White : School Clinic
Yellow : Parent
Pink: Prescribing Physician

Instructions on reverse side.

AUTHORIZATION FOR ADMINISTRATION OF PRESCRIBED MEDICATION AND/OR TREATMENT

Instructions for Completion:

1. The Clinic Aide should complete the top section of the form with the demographic information about the student.

2. The Physician then completes the center section with the prescribing information.

3. The bottom section is to be completed by the parent or legal guardian of the student involved. Parent´s signature should be obtained only after the parent has reviewed the information on the form.

4. The original of the completed form should be filed in the student´s cumulative records. Copies of the completed form should be distributed as follows:

   a. Clinic Aide
   b. Prescribing Physician
   c. Parent
   d. Any other appropriate individuals

The form should be renewed annually and also any time there is a change in the student´s medication and/or procedure.