THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

Coordinated Student Health Services • 1400 NW 14th Court, Ft. Lauderdale, FL 33311 • (754) 321-1575

Authorization for Medication/Treatment
Prescription or Over-the-Counter (OTC) Medication Form

PART I TO BE COMPLETED BY PARENT/GUARDIAN

I grant the principal or his/her designee the permission to assist or perform the administration of each medication to or for my child during the school day, including when he/she is away from school property for official school events. If my child has been authorized by his/her physician to self-administer their medication(s), I grant permission for my child to self-administer their medication at school and when they are away from school property for official school events. If my child is unable to self-administer their medication, I give permission for the principal/designee to perform the administration of the prescribed medication. I give permission to contact the physician/provider prescribing this medication(s) to clarify information provided on the authorization should the need arise.

Student Name_____ Date of Birth_____ Grade _____

School _____

Parent/Guardian Signature_____ Phone #_____ Date: _____

PART II TO BE COMPLETED BY PHYSICIAN/PROVIDER

Allergies:_____

Diagnosis: _____

MEDICATION	STRENGTH	DOSAGE	TIME(S) TO BE GIVEN	ROUTE	SIDE EFFECTS

Please check the appropriate box:

- ☐ I believe that this student has received adequate information on how and when to use their medication and they can use it properly.
- ☐ The student is to carry the medication on their person with the principal's knowledge. (An additional supply, to be used as backup may be kept in the school health room or other approved locations)
- ☐ The medication will be kept in the school health room.

Please list any limitations/precautions that should be considered:_____

_____

Physician's Name (Print)_____ Physician's Signature _____

Physician's Telephone #_____ Physician's Fax #_____

Date Completed _____

PART III TO BE COMPLETED BY SCHOOL HEALTH NURSE/DESIGNEE

Check as appropriate:

- ☐ Parts I and II are completed in entirety, including signatures.
- ☐ Prescription medication is property labeled by pharmacist.
- ☐ Medication authorization and medication label are consistent and pharmacy label is **NOT** expired.
- ☐ Over-the-counter medication is in an original container with the manufacturer's dosage and label, labeled with student's name and safety seal is intact
- ☐ Medication has been signed into clinic by parent and counted with school staff member.

_____ _____ _____

School Designee/Healthcare Personnel (Print) School Designee/Healthcare Personnel (Signature) Date