CITRUS COUNTY SCHOOLS SCHOOL HEALTH SERVICES	STUDENT AUTHORIZATION FOR PRESCRIPTION MEDICATION

STUDENT NAME:							
DOB:		AGE:		SCHOOL:		DATE:	

School district personnel shall be authorized to assist students in the administration of prescription medication according to Florida Statute 1006.062. Non-prescription medication shall be handled in the same manner as prescription medication. **All medication shall be brought to the school by an adult.**

My permission is hereby granted for the school principal, or the principal's designee to assist in the administration of medication to my child as described below:

Name of Medication:										
Amount to be Given:					**Time to be Given:**					
Health Condition:										
Allergies:										
Name of Physician:					**Phone #:**					
Special Instructions:										
What is the necessity for the medication to be provided during the school day?										
For Clinic Use Only • For Clinic Use Only • For Clinic Use Only • For Clinic Use Only • For Clinic Use Only • For Clinic Use Only • For Clinic Use Only										
Amount of Medication Received:	Date									
	Amount									
Expiration Date:	Exp. Date									
Reviewed by Nurse:					**Date:**					

- *ALL medication must be properly labeled from the pharmacy, and in the original container.*
- *A separate form is required for each drug.*
- *Forms MUST be renewed each school year.*
- *Any change in the above orders must be in writing from the physician.*
- *Expired medication or medication not picked up at the end of the school year will be disposed.*
- *Only the parent or guardian is allowed to sign this form. Medication must be brought to school by an adult.*
- *This medication will remain in the clinic at all times and will not be transported on the school bus. During school sponsored field trips, special arrangements will be made if medication administration is needed. An additional pharmacy labeled container will be required to transport medication, in the event of a school sponsored field trip.*

It is understood, by the undersigned, that school personnel will not be responsible for possible side effects from the administration of the above medication, and may contact the physician if there are concerns about the medication.

Parent/Guardian Name		Parent/Guardian Signature	
Phone Number:		Date:	

Emergency Names/Numbers:	Name:		Phone Number:	
	Name:		Phone Number:	

(Form shall be maintained as a part of the student's cumulative health record for 1 year from issuing date.) PFCSSC 42 6/96 rev 2/20/2014