IMAGINE SCHOOL LAKEWOOD RANCH
SCHOOL HEALTH SERVICES
MEDICATION AUTHORIZATION FORM

Student's Name	Sex	Date of Birth	Grade

School Name	FAX Number

This form is to provide medical and parental authorization for medication to be provided to my child while in school and away from school while participating in official school activites. Both the physician and parent/legal guardian portions of this authorization form must be completed entirely, signed, and returned to the school **before** the medication may be accepted/administered. **Over the counter medication such as Tylenol, cough syrup, Benadryl, Advil, and nutritional supplements also need this form filled out completely including the physician section.**

The following section is to be completed by the prescribing physician:

The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following medication which is necessary to be given in school. I am aware that this physician prescribed service may be administered by trained non-medical staff**. NOTE: a separate form must be completed for each medication prescribed or any change.**

Diagnosis for which medication will be required at school:	ICD9 Code:
Name of medication (example: Ritalin)	
Route (Please check one) ☐ Oral ☐ Topical ☐ Subcutaneous ☐ Inhaled ☐ Intramuscular ☐ Other (describe)	
Dosage (number of milligrams)	Amount (tab, tsp, cc/ml):
Frequency If medication is to be given at "scheduled times", at what time(s)? If medication is to be given "when needed", when would it be indicated and how many times can it be given?	_____ _____ _____ _____
(Please circle one) If applicable, is student authorized to carry on their person and use asthma inhalation medication, epinephrine auto-injector, or pancreatic enzyme supplement and self administer: YES NO	
List any significant side effects of the medication:	
Length of time (duration) medication is recommended:	

Physician's Name: _____ Phone #:_____ Fax #: _____
(Please print)
Physician's Address: _____

Physician's Signature: _____ Date: _____

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

I hereby grant permission to the principal (or his/her designee) of my child's school to administer the above prescribed medication to my child while in school and away from school while participating in official school activities (F.S. 1006.062). **It is my responsibility to notify the school if and when these orders change.** I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinary reasonably prudent person would under the same or similar circumstances. I understand the school will not be responsible for monitoring a student's self medication.

Name: _____ Relationship: _____

Cell Phone # _____ Home Phone # _____ Business Phone # _____

Signature: Parent/Legal Guardian _____ Date: _____

Prescription Pickup or Delivery Receipt For________________________________					Medication/Phone call Variance Report		Phone Contact		
Date of Transport	Amount of Med.	RX #:	Expiration Date	Signature(s) Parent/School Staff	Date of Variance	Description of Variance	Yes	No	Initial