

# Authorization for Medication Form 2022/2023 (All Grades)

## 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

#### 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 properly 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 \_\_\_\_\_