

This is a 2 sided form. If it is not, please request a new form.



Authorization to Assist In the Administration of Medication/Treatment

The parent/guardian of _____ (student name) requests that the school/child care staff give the following medication _____ (name of medication and dosage) at _____ (time(s)).

Date of Birth: _____

Teacher: _____

Grade: _____

Discovery Montessori School agrees to administer medication prescribed by a licensed health care provider. It is the parent/guardian's responsibility to furnish the medication in a separate container (provided by the pharmacist) with prescription. The parent agrees to pick up expired or unused medication within one week of notification by staff.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, and date medicine is to be stopped and licensed health care providers' name. Pharmacy name and phone number must also be included on the label. If requested most pharmacist will provide two containers for home and school use.

Over the counter medication must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

As the parent or guardian of the student named above, I request that the Head of School or Head of School's designee assist in the administration of medication/treatment prescribed for my child. I understand that under provisions of **Florida Statue 232.46, there shall be no liability for civil damages as a result of the administration of medication when the person administering such medications acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances.** I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the school staff designated to administer medication.

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____

Date: _____

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Student Name: _____

Medication/Treatment Order

All information must match the prescription label!

All medication must be properly labeled and in original containers. Complete one form for each medication/treatment to be administered. A new form must be completed if the dosage of a medication changes at any time.

It is necessary for the following medication/treatment to be given in school and during school sponsored activities. I am aware that non-medical personnel may administer this medication/treatment.

Name of medication/treatment: _____

Amount (Dosage): _____

Time to be given: _____ Date to start: _____ Date to end: _____

Health condition requiring medication: _____

Possible side effects: _____

Special instructions (i.e., take with or without food) _____

Physician ordering medication: _____

Physicians address: _____

Physicians phone number: _____ Fax: _____

Physicians Signature (required for prescription medications): _____

I authorize the physician to release information about this condition to school personnel.

Parent/Guardian Signature: _____

Best Phone: _____

Date: _____

Asthmatic Students: Possession Of Inhalers – Florida Statute 232.47

Florida law states an asthmatic student may carry a prescribed metered dose inhaler on his/her person while in school with approval from his/her parents and physicians.

The above named child may carry and self-administer his/her metered dose inhaler.

Parent/Guardian Signature: _____

Date: _____

Physicians Signature: _____

Date: _____