THE COLLEGIATE SCHOOL
FLORIDA STATE UNIVERSITY PANAMA CITY

Authorization to Administer Medication in School

Student Name: _____

DOB: _____

Grade: _____

Part I

Dear Parent and Healthcare Provider,

When considered medically necessary, students may receive medications and treatments as ordered by a licensed healthcare provider, during the school day. Please complete the following information.

Be advised that:

- Orders are valid for one school year.
- NO MEDICATION OR TREATMENT may be given by the school nurse or designee until this form is completed and properly labeled medication is received. THIS INCLUDES OVER THE COUNTER MEDICATIONS SUCH AS TYLENOL, MOTRIN, AND COUGH DROPS.
- A physician signature and a parent signature must be on this form.
- All medication must be stored in their original containers with an appropriate pharmacy label on each bottle.
- All labels will include the student's name, dose, frequency, route, time of administration of the medication.

Part II

Dear Healthcare Provider,

The parent initiates this request and has the responsibility for supplying medication and/or treatment supplies. Should the student display any adverse reactions, the parent will be contacted immediately, emergency care will be provided as needed and the medication/treatment discontinued. The parent will be responsible for contacting you for follow-up care as you deem necessary. Please sign below, acknowledging that you understand the procedure for management of side effects to prescribed medications or treatments. Thank you for your assistance.

_____	_____	_____
Physician Name (Printed)	Physician Name (Signature)	Date

Part III

Medication Treatment #1:

Name of Drug/Treatment _____ _____ _____

Dosage _____ Route _____ Frequency ____ _____ ___(include times and duration)

Medication form ☐ pill/capsule ☐ inhaler ☐ ear drops ☐ eye drops ☐ liquid ☐ injectable

Known adverse reactions/side effects _____ _____ _____

Prescribed treatment for side effects, if other than as outlined above _____ _____

Medication Treatment #2:

Name of Drug/Treatment _____ _____ _____

Dosage _____ Route _____ Frequency ____ _____ ___(include times and duration)

Medication form ☐ pill/capsule ☐ inhaler ☐ ear drops ☐ eye drops ☐ liquid ☐ injectable

Known adverse reactions/side effects _____ _____ _____

Prescribed treatment for side effects, if other than as outlined above _____ _____

Medication Treatment #3:

Name of Drug/Treatment _____ _____ _____

Dosage _____ Route _____ Frequency ____ _____ ___(include times and duration)

Medication form ☐ pill/capsule ☐ inhaler ☐ ear drops ☐ eye drops ☐ liquid ☐ injectable

Known adverse reactions/side effects _____ _____ _____

Medication Treatment #4:

Name of Drug/Treatment _____ _____ _____

Dosage _____ Route _____ Frequency ____ _____ ___(include times and duration)

Medication form ☐ pill/capsule ☐ inhaler ☐ ear drops ☐ eye drops ☐ liquid ☐ injectable

Known adverse reactions/side effects _____ _____ _____

Medication Treatment #5:

Name of Drug/Treatment _____ _____ _____

Dosage _____ Route _____ Frequency ____ _____ ___(include times and duration)

Medication form ☐ pill/capsule ☐ inhaler ☐ ear drops ☐ eye drops ☐ liquid ☐ injectable

Known adverse reactions/side effects _____ _____ _____

Part IV

Parent Permission:

I hereby give permission for my child to receive the above medications/treatments during school hours. I understand that medications may be administered by the school registered nurse or designee. This designee may be a non-medical person. If a treatment requires a medical or nursing assessment prior to administration, and a licensed medical person is not available, the medication and/or treatment will not be given. This medication and/or treatment is considered a medical necessity and ordered by a licensed healthcare provider. I hereby release the FSU Bay District, its agents and employees from any and all liability that may result from my child receiving this medication and/or treatment.

_____ _____ _____ _____

Parent/Guardian Signature Date Healthcare Provider Signature Date

_____ _____ _____ _____

Parent/Guardian Name (Print) Phone # Healthcare Provider Name (Print) Phone #