Form # 135
Rev. 7/10/19

PHYSICIAN AUTHORIZATION FOR STUDENT MEDICATION

Part I: Must be completed by a Physician/qualified medical provider. Use one form per medication.

Student:_____ Birth date:_____ Date _____

Allergies:_____Diagnosis:_____ICD-9 Dx code:_____

Medication (one per form):_____ Dose prescribed:_____

Route: Oral☐ Liquid☐ Other _____Time to be given_____ (must be specific & match medication label)

PRN ORDERS: If you are ordering medication "***AS NEEDED***", please specify under what conditions the child is to take (i.e. pain):_____ Special instructions:_____

NARCOTICS FOR PAIN MANAGEMENT WILL NOT BE ACCEPTED.

Inhaler/Nebulizer: Medication Name_____ Strength/Dose_____

Amount/# of puffs_____ Schedule (at what time)_____

If you are ordering the Inhaler "*as needed*" please specify under what conditions: (check all that apply)

☐ Shortness of Breath ☐ Coughing ☐ Wheezing ☐ Other_____

The student has been trained and has my permission to self-administer the MDI.

Check One: Student may carry inhaler ☐ **OR** Inhaler to be kept in clinic ☐

Medication side effects: _____

PHYSICIAN AUTHORIZATION

The parent knows of this request and has agreed to provide the supplies needed for the above medication.
Should the child manifest any of the above symptoms that may be caused by the medication, I understand that the parent will be contacted and the school health directives relating to emergency care will be followed.

Physician's Name (Print)	Physician's Signature	Date
License Number	Telephone	Fax Number

Part 2: Must be signed by parent/guardian prior to administration.

Parent/Guardian Permission

I understand that:

- Medication orders, including over-the-counter, are valid for this school year only and need to be renewed at the beginning of each school year.
- Medication, including over-the-counter, must be in original container and labeled to match physician's order for school use including field trips.
- I have the responsibility for supplying medication as needed.
- Medication orders become part of my child's permanent school health record.
- I give permission to the school nurse to share information with appropriate school staff relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
- I give permission to the school nurse to contact the above health care provider for information relevant to the prescribed mediation administration as he/she determines appropriate for my child's health and safety.
- I may retrieve the medication from the school at any time; however the medication will be destroyed if it is not picked up within one week following termination of the order or one day beyond the last day of the school year.

I hereby give permission for my child (named above) to receive medication during school hours administered by the nurse or trained principal designee. I understand the School District and Treasure Coast Classical Academy under take no responsibility for the administration of the medication. This medication has been prescribed by a licensed physician. I hereby release the School District and its agent and employees as well as Treasure Coast Classical Academy from any and all liability that may result from my child taking the medication.

Parent/Guardian Name (Print)	Signature	Date
Health Assistant (Print)	Signature	Date
School Nurse (Print)	Signature	Date