



Parental Authorization for Administration of Prescription Medication

Student Name: _____ Student DOB: _____

Parent/Guardian Name: _____ Phone: _____

With written physician orders and parent/guardian permission, the school nurse or designated staff may assist students with medication administration. Medications must be provided in the original, pharmacy-labeled container. Parents may request separate bottles for home and school use. Written permission is also required for students to carry and self-administer prescribed or emergency medications, including EpiPens, Auvi-Q, inhalers, and seizure medications.

To Be Completed by Health Care Provider:

Name of Medication	Reason	Dosage	Route	Time	Refrigerate (Y/N)

Diagnosis/Significant Findings: _____

Medication Allergies: _____ ☐ No Known Allergies

I understand that under provisions of Florida Statute 232.46, school personnel cannot be liable for reactions or side effects from the administration of medication. I also grant permission for school personnel to contact the physician if there are questions or concerns about the medication. I have read the guidelines and agree to abide by them.

AS THE PARENT/GUARDIAN, I HAVE ADVISED THAT THE ABOVE NAMED STUDENT MAY USE THE MEDICATION(S) OR TREATMENT(S) AS INDICATED. SHOULD THERE BE ANY CHANGE IN MEDICATION(S)/DOSAGE OR TREATMENT(S), I WILL ADVISE BY COMPLETING A NEW FORM. I GIVE MY PERMISSION FOR AHN/THE SCHOOL NURSE TO ADMINISTER THE INDICATED MEDICATION(S) TO MY CHILD.

PARENT/GUARDIAN AND PHYSICIAN SIGNATURES ARE REQUIRED

Parent/Guardian Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

OVERNIGHT FIELD TRIP MEDICATIONS: Please list any medication your student may need while off campus for an overnight field trip/retreat/mission trip.

Medication	Dosage Ordered	Time(s) Taken