Medication/Treatment Authorization Form PP-SR-125
Sumter County Schools

This section is to be completed by the parent/guardian:

Student Name: _____ Gender: _____ Grade: _____ DOB: _____
Parent/Guardian Name: _____ Relationship to Student: _____
Address: _____
Home Phone: _____ **Emergency Phone:** _____ Cell Phone: _____
List student allergies: _____

I hereby grant permission to the principal or his/her designee of _____ School to assist in the administration of the prescribed medication and/or treatment to my child while in school and away from school while participating in official school activities (F.S.1006.062). **It is my responsibility to notify the school if and when these orders change.** I give permission for school district personnel and the physician to exchange pertinent information pertaining to my child's condition/progress. I authorize the School Nurse to contact the prescribing healthcare provider for clarification, if needed.
Parent/Guardian Signature: _____ Date: _____
Parent/Guardian Name (Print) _____ Date: _____

The following section is to be completed by the prescribing health care provider:

A separate form must be completed for <u>each medication or treatment prescribed</u>.
The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following medication/treatment, **which is necessary to be given in school.** I am aware that trained non-medical staff may administer this medication/prescribed service.
This order is to be effective for the school year: 20_____ - 20 _____, OR earlier stop date _____

Diagnosis/Treatment:
Name of medication: Strength: (i.e. mg/tab)
Instructions: Give: **Amount** (i.e. # of tablets or teaspoon) _____ **Exact time (**i.e. lunchtime, noon**)** _____ **Frequency** (i.e. every 6 hrs) _____ **Duration** (i.e. for 5 days, school year)_____ **ALL PRN medication orders must note frequency** _____
Route (please circle) Oral Topical I.M. Subcutaneous Inhaled Other (describe) _____
Possible side effects:
Special instruction when administering medication: (i.e. take with food, give after meal, requires refrigeration etc.)

	(Please circle)	
Is student authorized to carry and use the Asthma inhalation medication and/or Epinephrine Auto Injector?	**YES**	**NO**
Has student been instructed on the use of asthma inhaler and/or epinephrine auto injector?	**YES**	**NO**
Is student authorized to self-administer pancreatic enzymes?	**YES**	**NO**
Has student been instructed in the use of pancreatic enzymes?	**YES**	**NO**

Other information
Health Care Provider (print) _____ Address _____ Phone _____ Fax _____ Provider Signature_____ Date _____
Medication **<u>order reviewed</u>** by school RN _____ Date _____ Medication **stopped** by Parent/Guardian _____ Date _____