THE SCHOOL BOARD OF ST. LUCIE COUNTY
4204 Okeechobee Road, Fort Pierce, FL 34947
772-429-4570

PHYSICIAN'S AUTHORIZATION FOR MEDICATION

Part I: (To be completed by physician's office)

To the Principal of ____ School

Name of Student/Patient ____DOB _______________

In order to keep this child in optimum health and to help maintain maximum school performance and attendance, it is necessary the medication listed below be given during school hours. (No injections are given except in extreme emergencies, such as allergic reaction to insect stings). **ONE MEDICATION PER FORM PLEASE**

MEDICATION Name: ____Dosage:_______________________
FORM: Pill/Tab ☐ Capsule ☐ Liquid ☐ Other________________ ICD-9 DX Code _________________
Schedule: (how often or what time)

____

PRN ORDERS

IF YOU ARE ORDERING MEDICATION "AS NEEDED", PLEASE SPECIFY UNDER WHAT CONDITIONS THE CHILD IS TO TAKE i.e. pain: ____
ANY SPECIAL INSTRUCTIONS: ____
INHALER/NEBULIZER: Medication Name: __________________________# of puffs ______________________
Schedule: (how often or 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 ______________ **Inhaler to be kept in clinic**______________

____ ______________________________________
Physician Name (Please Print) Physician Signature

Part II: (to be completed by parent/guardian)
I HEREBY GIVE PERMISSION:

- For my child named above to receive medication during school hours. A licensed physician has prescribed this medication.
- 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.
- To the school nurse to contact the above health care provider for information relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.

_____________________________ ______________________ __________________
Parent/Guardian Signature Telephone Date

Part III: (for school use only)

Date Rec'd by school: __________________ **By:** ____

Health Paraprofessional: ____

Reviewed By: ____ **Date**______________

Approved By: ____ **Date**______________