SCHOOL HEALTH SERVICES
HEALTH CARE PROVIDER/PARENT CONSENT FOR MEDICATION ADMINISTRATION

Dear Health Care Provider: **School Year**_____
The following student is requesting medication administration during school hours.

NAME: _____ DOB:_____ SCHOOL: _____

Policy for the administration of over the counter and prescription medication is as follows:
-Only Medication ordered by a licensed health provider (LHCP) will be administered in the school setting.
-All Medication orders will expire at the end of the school year.
-Written parent permission is required prior to any medication administration. (See parent section below)
-Over the counter (OTC) - All OTC medication, such as but not limited to Benadryl, Motrin, and cough drops require a written order from the LHCP prior to administration. Medication must be in the original package and labeled with the students name and dosage instructions.
-Prescription Medication- Written orders should be requested for any prescription medication within 48 hours from the health care provider.
Please write the medication orders below. Please be specific with dates, parameters, etc. We appreciate your cooperation with this request.
DIAGNOSIS:

Medication	**Time of Day to be taken**	**Amount/ Number To be taken**	**Duration of med Beginning and end date**

Generic substitute will be allowed unless specified below:
____ Check if Generic Substitution is not allowed.

Please report the following adverse effects to the prescriber's office.

Health Care Provider Signature: **Please Print Health Care Provider Name:** **Date**
Health Care Provider Phone Number: Health Care Provider Fax

Parent Consent for Medication Administration

Florida Statute 1006.062 requires written parental consent for a student to take medication during the school day
Please refer to "Guidelines for Administration of Medication" on the following page
I agree with the above prescribed medication regimen and authorize the personnel of XXXXX XX SCHOOL to administer medication to my child/student. It is understood that the medication will be administered if needed on field trips. I also authorize the school nurse to contact the prescribing licensed health care provider or his/her designee to exchange information concerning the purpose, dosage and effects of this medication.

Please Print Parent /Guardian Name Contact phone number Alternate Phone

Parent/Guardian Signature Date

7/16 PT