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 and Motrin 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 Date to be Taken:_____ **Amount/Number to be Taken**_____

Duration of Meds: **Beginning**_____ **End**_____

_____

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 100.062 requires written parental consent for a student to take medication during the school day. I agree with the above prescribing medication regimen and authorized the personnel of Bishop Verot Catholic High 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 effect of this medication.

_____

Please Print Parent/Guardian Name Contact Phone Number Date

_____

Parent/Guardian Signature Email Address