



CITRUS COUNTY SCHOOLS  
SCHOOL HEALTH SERVICES

AUTHORIZATION FOR MEDICATION  
Prescription/Over the Counter

Student Name:			
DOB:	Age:	School:	Date:
Health Condition(s):			
Parent/Legal Guardian Name:		Phone Number(s):	

*School District personnel shall be authorized to assist students in the administration of prescription medication according to Florida Statute 1006.062. Non-prescription/over the counter medication shall be handled in the same manner as prescription medication.*

My permission is hereby granted for the school Principal, or the Principal's designee to assist in the administration of medication to the student as described below:

Medication:		
Dose:	Circle: Whole Half Liquid	Specific Time: ____:____ AM or PM
Allergies:		
Special Instructions:		
Physician Name:		Phone Number:
Physician Signature:		Date:
Parent/Legal Guardian Signature:		Date:

**Parent Initials**

_____	<b><u>ALL medication must be properly labeled and in the original container.</u></b>
_____	A separate form is required for each medication.
_____	Forms MUST be renewed each school year.
_____	Authorization form will not be accepted without Physician's signature.
_____	Any change in the above orders must be in writing from the Physician.
_____	Expired medication or medication not picked up at the end of the school year will be disposed.
_____	Only the Parent or Legal Guardian shall sign this form.
_____	<b><u>Medication must be brought to school by an adult.</u></b>
_____	This medication will remain in the clinic and will not be transported on the school bus.
_____	During school sponsored field trips, arrangements will be made if medication is required.
Reviewed by School Nurse:	Date: