CITRUS COUNTY SCHOOLS **SCHOOL HEALTH SERVICES**	**PHYSICIAN'S 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

_____ **ALL medication must be properly labeled and in the original container.**
_____ 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.
_____ **Medication must be brought to school by an adult.**
_____ 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:

(Form shall be maintained as part of the student's cumulative health record for 7 year from issuing date.) PFCDSS-187 07/21/2022