FLORIDA ATLANTIC UNIVERSITY
Laboratory Schools

Authorization to Administer Medication in School

CURRENT DATE	STUDENT NUMBER

STUDENT NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH	SEX	GRADE	SCHOOL

When considered medically necessary, students may receive medications and treatments as ordered by a licensed healthcare provider, during the school day. Please complete the following information. Be advised that orders are valid for one school year.

- NO MEDICATION OR TREATMENT may be given by the school nurse or designee until this form is completed and properly labeled medication is received. THE ONLY EXCEPTION IS OVER-THE-COUNTER MEDICATION TO RELIEVE HEADACHES SUCH AS TYLENOL OR MOTRIN.
- A physician signature and a parent signature must be on this form.
- All medications must be stored in their original containers with an appropriate pharmacy label on each bottle. All labels will include the student's name, does, frequency, route, time of administration of the medication.

Dear Healthcare Provider,

The parent initiates this request and has the responsibility for supplying medication and/or treatment supplies. Should the student display any adverse reactions, the parent will be contacted immediately, emergency care will be provided as needed and the medication/treatment discontinued. The parent will be responsible for contacting you for follow- up care as you deem necessary. Please sign below, acknowledging that you understand the procedure for management of side effects to prescribed medications or treatments. Thank you for your assistance.

Medications: (Please check all appropriate boxes)

☐ Name of Drug or Treatment #1: _____

I believe the above named student has received adequate information and they can use the medication properly. ☐ Yes ☐ No

☐ The student is to carry the medication on their person. ☐ The medication is to remain in the Clinic.

Dosage: _____ Route: _____ Frequency (include times and duration): _____

Medication form: ☐ Pill/Capsule ☐ Inhaler ☐ Ear Drops ☐ Eye Drops ☐ Liquid ☐ Injectable

Known adverse reactions/side effects: _____

Prescribed treatment for side effects, if other than as outlined above: _____

☐ Name of Drug or Treatment #2: _____

I believe the above named student has received adequate information and they can use the medication properly. ☐ Yes ☐ No

☐ The student is to carry the medication on their person. ☐ The medication is to remain in the Clinic.

Dosage: _____ Route: _____ Frequency (include times and duration): _____

Medication form: ☐ Pill/Capsule ☐ Inhaler ☐ Ear Drops ☐ Eye Drops ☐ Liquid ☐ Injectable

Known adverse reactions/side effects: _____

Prescribed treatment for side effects, if other than as outlined above: _____

☐ Name of Drug or Treatment #3: _____

I believe the above named student has received adequate information and they can use the medication properly. ☐ Yes ☐ No

☐ The student is to carry the medication on their person. ☐ The medication is to remain in the Clinic.

Dosage: _____ Route: _____ Frequency (include times and duration): _____

Medication form: ☐ Pill/Capsule ☐ Inhaler ☐ Ear Drops ☐ Eye Drops ☐ Liquid ☐ Injectable

Known adverse reactions/side effects: _____

Prescribed treatment for side effects, if other than as outlined above: _____

SIGNATURE OF HEALTHCARE PROVIDER	PRINTED NAME OF HEALTHCARE PROVIDER	PHONE NUMBER	DATE

CURRENT DATE	STUDENT NUMBER

I hereby give permission for my child to receive the above medications/treatments during school hours. I understand that medications may be administered by the school registered nurse or designee. This designee may be a non-medical person. If a treatment requires a medical or nursing assessment prior to administration, and a licensed medical person is not available, the medication and/or treatment will not be given. This medication and/or treatment is considered a medical necessity and ordered by a licensed healthcare provider. I hereby release the Florida Atlantic University Laboratory Schools, its agents and employees from any and all liability that may result from my child receiving this medication and/or treatment.

SIGNATURE OF PARENT OR GUARDIAN	PRINTED NAME OF PARENT OR GUARDIAN	PHONE NUMBER	DATE

SIGNATURE OF HEALTHCARE PROVIDER	PRINTED NAME OF HEALTHCARE PROVIDER	PHONE NUMBER	DATE

(for Office Use Only):

Comments:

Medication/Treatment Received:

Name of Drug or Treatment: _____

Date: _____ Amount: _____ Nurse Signature: _____

Logged in Medical Administration Book: ☐ Yes ☐ No Secured in Locked Cabinet: ☐ Yes ☐ No

Name of Drug or Treatment: _____

_____ Amount: _____ Nurse Signature: _____

Logged in Medical Administration Book: ☐ Yes ☐ No Secured in Locked Cabinet: ☐ Yes ☐ No

Name of Drug or Treatment: _____

_____ Amount: _____ Nurse Signature: _____

Logged in Medical Administration Book: ☐ Yes ☐ No Secured in Locked Cabinet: ☐ Yes ☐ No