St Lucie Public School-Division of Student Services
PHYSICIAN AUTHORIZATION FORM

Part 1 (to be completed by physician's office; one medication per form)

Name of Student_____ DOB _____
It is necessary to administer the below medication during school hours:

Medication: _____ ( )Pill/Capsule; ( )Injection; ( )Liquid; ( ) Other_____

Dose to be administered (in mg, mcg, puffs, etc.): _____Amount of liquid or count of pills: _____

Time(s) to be administered: _____Route: ( ) oral; ( ) inhaled; ( ) topical; ( ) IM; ( )other

Frequency for as needed medication: _____

Indications for as needed medication: _____

Special Instructions: _____

( )Self-carry and Administer Authorization:

According to Florida statutes students are allowed to carry and self-administer **Rescue Inhalers**, **Epinephrine auto injectors, pancreatic enzymes, diabetic supplies and equipment.** I believe that this student has received adequate information on how and when to use their medication and they can use it properly. The student is to carry the medication on their person with the principal's knowledge. (An additional supply, to be used as backup, may be kept in the school health room).
If the student is not authorized to carry by the health care provider and the parent/guardian, the medication will be kept in the school health room.

_____ _____
Physician Signature Date

_____ _____ _____
Physician Print Name Telephone Fax

I authorize the principal or principal's designee to assist or perform the administration of the medication for my child. I certify that the prescribed medication is in its original container and that it is medically necessary, according to my physician's instructions, for this medication to be provided during the school day and when my child is on a field trip for educational purposes (which can extend beyond normal school hours). I understand this medication will be given only according to the directions on the Physician's Authorization Form as prescribed by the doctor. I further understand that, at the end of the school year, it will be my responsibility to pick- up any unused medication by the last day of the school year, otherwise the school will dispose of the medication.
If indicated by the physician, that the medication be self-carry, I give my permission for my child, named in part I, to self-administer the medication. A licensed health care provider has prescribed this medication, and my child has been instructed on its use.

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Print Name Date

Health Paraprofessional: _____ _____
Date

Principal: _____ _____
Date

Registered Nurse: _____ _____
Date