Okeechobee County School Health Services
PHYSICIAN'S AUTHORIZATION FORM
Daily and As Needed Medication

Name of Student/Patient: ___________________________ **DOB:** ___________ **Date:** ______________

Part I: To be completed by physician's office

It is necessary for the medication listed below be given during school hours:

[ ] DAILY MEDICATION ORDERS [ ] PRN MEDICATION ORDERS

Medication:____**Dosage:**______________________

Form (please circle): Pill/Tab Capsule Liquid Other____

Schedule (how often or what time. If daily, please give specific time): __________________________

____

Medication ordered for:____

Any special instructions: ____

____________________________	______________________________	_____________________
Physician Name (please print)	Physician Signature	Office Number

Part II: To be completed by Parent/Guardian

I HEREBY GIVE PERMISSION (POR LA PRESENTE DOY PERMISO)::

- For my child named above to receive medication during school hours. A licensed physician has prescribed this medication. To the school nurse to share information with appropriate school staff relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety. To the school nurse to contact the above health care provider for information relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.

*Para que mi hijo nombrado anteriormente reciba medicamentos durante el horario escolar. Un médico con licencia ha prescrito este medicamento. A la enfermera de la escuela para compartir información con el personal escolar apropiado relevante para la administración de medicamentos prescritos, ya que determina apropiado para la salud y seguridad de mi hijo. A la enfermera de la escuela que se ponga en contacto con el proveedor de atención médica anterior para obtener información relevante para la administración de medicamentos prescrita, ya que determina apropiada para la salud y seguridad de mi hijo.

___________________________________	___________________	__________________
Parent/Guardian Signature (Firma del Padre/Tutor)	Telephone Number (número de teléfono)	Date (Fecha)

Part III: School Use Only

Reviewed by: ____ ____________________

School Health Personnel Date

ATTENTION: Please remember to pick-up student medication(s) by the last day of school, all remaining medications will be disposed of per school policy

For School Nurse/MD Office Use: Return to ________________________*at School*_______________________

Fax number _____________________________

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