**Florida Department of Health Washington County Medication Consent Form**

To be completed by a licensed healthcare provider

**School Year 2022-2023**

I hereby certify that it is necessary for \_\_\_\_\_\_

**(Student’s Name)**

\_\_\_\_\_\_

**(Date of Birth) (Age) (School) (Grade) (Teacher)**

to be given the medication listed below during school hours. It is not possible for the medication to be given at home due to the dosing schedule. Without this medication, the student will not be able to attend school. The medication consent form must be completed by a licensed healthcare provider and signed by the parent or guardian at the beginning of each school year. **Start Date**: \_\_\_\_\_\_\_\_\_**Stop Date**:\_\_\_\_\_\_\_\_\_

**Diagnosis:** **Allergies:** \_\_\_\_

**Medication:­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Generic Name (if used):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dosage:** **Route:** \_\_\_\_\_\_\_\_\_\_

**Time of Administration:** \_\_\_\_

**Is self-medication permitted and recommended?** Yes\_\_\_\_\_ No\_\_\_\_\_

If “yes” I hereby affirm this student has been instructed on proper self-medication administration of the prescribed medication.

Students are permitted to carry on their person while in school and self-administer Epi-Pens, metered dose inhalers, diabetic supplies and/or pancreatic enzyme supplies if ordered by a licensed healthcare provider.

**Do you recommend this medication be kept “on person” by the student?** Yes\_\_\_\_\_\_ No\_\_\_\_\_

**Possible side effects and/or special instructions:** (Should the medications be given with food, milk, water, crushed, broken in half, etc.)

**It is understood by the undersigned that the school personnel will not be responsible for possible side effects from the administration of prescribed medication. By signing this document, the parent/guardian acknowledges the medication listed above will be discarded one week after the current school term per school health policy.**

Physician’s Signature Date Parent/Guardian Signature Date

Physician’s Name Printed Parent/Guardian Name Printed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Phone Number & Fax Number Physician’s Address

**Revised – 05/2022**