MEDICATION/TREATMENT AUTHORIZATION FORM -- ALLERGY

Name:_____ DOB:_____ SCHOOL: _____

To be completed by PARENT/GUARDIAN--Parent/Guardian Permission

I hereby grant permission to the principal or his/her designee of _____ School to assist in the administration of the prescribed medication and/or treatment to my child while in school and away from school while participating in official school activities (F.S. 1006.062). It is my responsibility to notify the school if and when these orders change. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication and/or treatment where the person administering such medication and/or treatment acts

DIAGNOSIS: _____

Type of Allergy

Medication _____

Food _____

Environmental Allergens _____

Insect Bites/Stings _____

Symptoms of Allergy

Check the box next to any of the following symptoms that child has experienced:

Hives or giant hives
Swelling of _____
Difficulty in breathing – wheezing
Shock
Fainting – dizziness
Other (Des
g –

MEDICATION/TREATMENT AUTHORIZATION FORM

Instructions: For medication/treatment administration during school hours-- see Requirements below.

State regulations and school board policy require that you and your child's doctor must provide written permission for any prescribed medications, including over-the-counter (OTC) medications and/or medical treatments.

The administration of prescribed medications/treatments to a student during school hours will only be permitted when the failure to do so would jeopardize the health of the student