FLORIDA DEPARTMENT OF HEALTH HOLMES/WASHINGTON COUNTY MEDICATION CONSENT FORM

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 is to be administered during the period between_____ (beginning date) until_____ (ending date) .

Diagnosis:_____ **Allergies:**_____

Medication:_____
(Please specify if it is okay for generic to be given)

Dosage:_____ **Route:**_____

Time of Administration:_____

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