Miami-Dade County Public Schools
giving our students the world

AUTHORIZATION FOR MEDICATION

NAME OF STUDENT _____ SCHOOL _____

TREATMENT PLAN (to be completed by physician)

DATE _____

DIAGNOSIS

_____

_____

MEDICATION & DOSAGE _____

SIDE EFFECTS

_____

_____

PURPOSE OF MEDICATION _____

DIRECTION FOR ADMINISTRATION BY SCHOOL PERSONNEL

_____

_____

_____

_____
PHYSICIAN

_____
ADDRESS

_____
PHONE NUMBER

_____
ALLERGIES

NOTE: If the medication is to be administered for an extended period of time, see paragraph F on the reverse side.

_____
Signature of Physician

PARENTAL PERMISSION (to be completed by parent or guardian)

DATE _____

My permission is hereby granted to the School Principal or his/her specified delegated personnel to administer prescribed medication to my _____
Relationship

_____
Name of Student

NOTE: If the medication is to be administered for an extended period of time, see paragraph F on the reverse side.

_____
Signature of Parent or Guardian