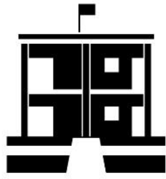

PARKWAY
CHRISTIAN ACADEMY

AUTHORIZATION FOR MEDICATION/TREATMENT

All medications and/or treatment, equipment or supplies must be provided by the parent.
Complete one form per medication, including over the counter. A new authorization must be completed at the beginning of each school year or anytime a dosage is changed.

Child's Name: ________________________________ ________ ____________
First Last Grade Date of Birth

____ ______________
Physicians Name Address Phone

I hereby authorize the above named physician and Polk County Schools/Florida Department of Health in Polk County staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand Polk County School District protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed, or electronic.

I request that my child be assisted in taking the medication or treatment described below at school by authorized persons as permitted by me and my physician *(see below).*

__________ ______________________________ ______________
Date Parent/Guardian Signature Phone

Diagnosis for which medication or treatment is given (If applicable): ______________________________

Name of medication or treatment: ______________________________

Dose: ______________________________

If medication is treatment is to be given at school, at what time? ______________________________

If medication or treatment is to be given "When needed", describe indications: ______________________________

____

How soon can it be repeated? ______________________________

List significant side effects: ______________________________

Other Information:

____

____