# HEART TO HEART
# SCHOOL MEDICATION AUTHORIZATION FORM

Name of Child _____ Date of birth: _____

School _____ Phone: _____ FAX # _____

**Florida Statute §1006.062 authorizes school personnel to assist students with prescription medications under strict guidelines, requiring a doctor's order, a parent's consent form, and the medication in its original, labeled container. Additionally, other statutes permit students to self-administer certain medications, such as epinephrine auto-injectors (under Statute §1002.20) and bronchodilators (also under Statute §1002.20), provided the school has a physician-approved protocol and the student is at risk for life-threatening allergic reactions or respiratory distress.**

## PHYSICIAN'S ORDER (*To be completed by health care provider) **Only one medication per form***

Name of medication/strength of tablet, capsule or liquid _____

This medication is a controlled substance ☐ Yes ☐ No

Dosage: _____ How Often? _____

Time to be given at school: _____ Route to be given: _____

Reason for medication/Diagnosis: _____

Possible side effects: _____

☐ Student has been instructed by physician in self-administration and may carry the inhaler with them

☐ Student has been instructed by physician in self-administration and may carry the Epi-Pen with them

Comments _____

_____

*It is necessary for this medication to be taken during the school day at the time(s) indicated above.*

_____ _____

Print Name of Licensed Physician Signature of Licensed Physician

_____ _____ _____ _____

Address Phone Date License #

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## TO BE COMPLETED BY PARENT BEFORE GIVING FORM TO DOCTOR

I request that my child, _____ , be assisted in taking the above prescribed medication at school by authorized persons. I will comply with the school's policies and procedures. I will notify the school if there are changes in my child's health status, changes in medication or change in health care provider.

I authorize exchange of information between my child's Physician, District Nurse, or site administrator with regard to this medication request.

_____ _____ _____

Parent/Guardian Signature Date Phone (home)

_____

Phone (emergency)

**Name of medication to be given at school** _____ **Time to be given at school** _____

*Form must be renewed every 12 months or whenever the prescription changes.*

dh 8/20/2025