**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**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