Florida Department of Health Holmes County Medication Consent Form

To be completed by a licensed healthcare provider
School Year 2022-2023

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 consent form must be completed by a licensed healthcare provider and signed by the parent or guardian at the beginning of each school year. **Start Date**: _____**Stop Date**:_____

Diagnosis:_____ **Allergies:**_____

Medication:_____ **Generic Name (if used):**_____

Dosage:_____ **Route:**_____

Time of Administration:_____

Is self-medication permitted and recommended? Yes_____ No_____
If "yes" I hereby affirm this student has been instructed on proper self-medication administration of the prescribed medication. Students are permitted to carry on their person while in school and self-administer Epi-Pens, metered dose inhalers, diabetic supplies and/or pancreatic enzyme supplies if ordered by a licensed healthcare provider.

Do you recommend this medication be kept "on person" by the student? Yes_____ No_____

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

Revised – 05/2022