Hillsborough County
PUBLIC SCHOOLS
Preparing Students for Life

SCHOOL HEALTH SERVICES
PARENTAL AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Student name: _____ Student #: _____ DOB: _____
Last First Middle

School: _____ Grade: _____

Known allergies: _____

As the parent/guardian of the student named above, I request the principal's designee or HOST trained personnel to administer the medication(s) described below to our/my child at school.

Medication	Amount/ Strength	Dose	Med. Exp. Date	Time	Purpose of Medication	Date Begins	Date Ends

Name of physician, APRN, or PA:_____ Phone Number:_____

I understand that the provision of Florida Statute 1006.062, school personnel cannot be held liable for reactions or side effects from the administration of the medication(s). I also grant permission for school personnel to contact the physician, APRN, or PA if there are questions or concerns about the medication(s). I hereby authorize School Health Services 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 Hillsborough County Public Schools 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 hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this authorization form. I understand that I am responsible to furnish/restock all supplies and medications and that any unused medication that is not retrieved by me at the end of the school year will be destroyed. I have read the attached guidelines and agree to abide by them.

Please list the medications your child takes at home (include dosage and times).

_____

_____

Where does the child go after school? _____

Parent/guardian of students attending HOST (or any before/after-school care program), will need to make arrangements with the before/after school programs when medicines or treatments are needed.

PLEASE NOTE EARLY RELEASE DAYS MAY IMPACT ADMINISTRATION OF MEDICATION.

Early release time:_____ Will medication be given? Yes No (Circle)

_____ _____ _____
Parent/Guardian Signature Primary Daytime Phone Date

Distribution: School Nurse and/or Trained HOST Personnel
SB 87034 (Rev. 08/22/2019)