I have read Pasco County Schools’ *General Guidelines for Administration of Medication at School* and

permission is hereby granted to  Pasco County Schools’

 (Name of school)

trained personnel to administer the following medication to:

                       \_\_\_

(Student’s name) (Student #) (Grade) (DOB)

for the treatment of       .

 (Health condition)

Name of prescribing Health Care Provider:

Known Allergies:

Name of medication:

Dose of medication:       Route of medication:       Time to be given at school:

Special instructions (including reasons for which medication must be administered during the school day or

at after school activities):

Possible reactions / side effects:

I hereby authorize designated Pasco County Schools’ 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 Pasco County 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 acknowledge that I am the parent/guardian of the student listed above and I have the rights and authority set forth in the Parent’s Bill of Rights and related laws, and I further acknowledge that I have had the opportunity to review the district’s resources identifying my rights (including the notices located at

<https://www.pasco.k12.fl.us/ssps/page/parent_notices>, and pursuant to the Parent’s Bill of Rights, Chap.1014, Fl. Stat.),

and my acknowledgement and my consent is indicated by my signature below. I understand that the form must be completed each school year.

 Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature of Parent / Guardian)

Note: Give parent copy of *General Guidelines for Administration of Medication at School*