CITRUS COUNTY SCHOOLS SCHOOL HEALTH SERVICES	Authorization for Medication Administration

One Medication Per Card

Student Name (Last, First)	Student ID	Date of Birth	Grade	Age
Parent/Legal Guardian Name (please print)	Phone Number (primary)	Phone Number (secondary)		
Medication	Reason			

I give permission and request _____ School/Center to administer the above medication to the student named above and to contact the prescribing Physician with questions/concerns related to the medication. I also hereby give permission for release of medical information regarding the above medication from the Physician to the School Board of Citrus County, including the above-named School/Center and staff from the District Administration.

In order for the student to receive medication in school, I agree to the following.

- I will hand deliver all medications to the school. (NO STUDENT SHALL TRANSPORT MEDICATIONS TO OR FROM SCHOOL).
- The prescription medication is in the original labeled container from a pharmacy or physician's office, altered labels will not be accepted.

Parent or Legal Guardian must

- Notify school of any discontinuation of medication.
- Any changes in dosage, time or reintroduction of a medication requires physician's authorization.
- Cut any medication prior to delivery to school.
- Pick-up and sign-out all unused/expired medication. Any medication not picked-up will be destroyed at the end of the school year.
- Recognize that narcotics and non-FDA-regulated non-prescription herbal products will not be given at school.
- Fill out new medication cards and authorization forms each school year.
- Administer first dose of a new medication at home.

Having read the above conditions, I certify that I have legal authority to consent to the statements herein, including medical treatment for the student named above and the administration of medication at school.

Parent/Legal Guardian Signature _____ Initial _____ Date _____

Date	Medication Name	Medication Expiration Date	Pills W=Whole Pills H=Half L=Liquid (Circle one)	Number Received	Parent/Legal Guardian Signature	Staff Signature
			W H L			
			W H L			
			W H L			
			W H L			
			W H L			
			W H L			
			W H L			
			W H L			
			W H L			
			W H L			

Authorization for Medication Administration

Health Room Attendant and Nursing Notes

Date	Notes

Field Trip Records-By signing below, I acknowledge that I have received and demonstrated/verbalized appropriate child specific training required for the administration of this medication.

Date	Staff Signature Medication Signing out	Staff Signature Medication Received	Medication Count out	Staff Signature Signing In	Staff Signature Medication Returned	Medication Count in