AUTHORIZATION FOR MEDICATION

ONE MEDICATION PER FORM

SCHOOL YEAR: 20_____20____

STUDENT'S PICTURE

____ ____________ ________
Student's Name Date of Birth Grade

________________________________ __________________ ________________
School Name Phone Number Fax Number

TREATMENT PLAN (To be completed by Medical Provider)

Diagnosis: ____

ALLERGIES: ____

Medication/Strength/Route: ____

Dose & Frequency: ____

Directions: ____

____

Side Effects: ____

Has student been trained in the use_________________________ (medication's name) Yes ☐ No ☐

Is student authorized to carry *and* self-administer_______________ (medication's name) Yes ☐ No ☐

I am aware that this medication may be administered by school personnel/non-medical staff.

________________________________ ___________________________ ___________
Provider's Name (PLEASE PRINT/STAMP) Signature Date

____ __________________ __________________
Address Phone Fax

PARENTAL/GUARDIAN PERMISSION

I, ______________________________________, give my permission to The SEED School of Miami specified
Parent/Guardian Name (PLEASE PRINT)

trained medication administration delegated personnel to administer prescribed medication to:
____.
(Student's name and Relationship)

________________________________ ____________________ __________________
Signature of Parent/Guardian Phone Date