School District of Indian River County
"A CommUNITY Partnership Toward Educational Excellence"

School District of Indian River County
In collaboration with
Florida Department of Health in Indian River County

Florida HEALTH

PHYSICIAN'S AUTHORIZATION FOR AS NEEDED OR EMERGENCY MEDICATION SCHOOL YEAR 2019-2020

Name of Student _____ **DOB** _____

The above named student is under my medical supervision for the diagnosis described below. I have prescribed the following medication/treatment. I am aware that trained non-medical staff may assist the student with this physician prescribed medication or treatment.

ONE MEDICATION PER FORM

Diagnosis/ICD 10 Code: _____

Allergies: _____

Medication name: _____ Dosage: _____

Route: _____ Schedule: _____
(Interval Between Doses)

(_____)

SPECIFY SYMPTOMS ABOVE FOR WHICH THE STUDENT IS TO TAKE THE MEDICATION
(i.e. cough, wheezing, shortness of breath, headache, orthodontic discomfort, etc.**)**

For Asthma Inhalers or Epinephrine Auto-Injectors ONLY

Student has been instructed in proper use of an asthma inhaler Yes ☐ No ☐

Student has been instructed on how to self-administer an auto-injector Yes ☐ No ☐

Student is competent to carry and self-administer this medication at school and while away on school sponsored activities Yes ☐ No ☐

SPECIAL INSTRUCTIONS

_____

_____

_____	_____	_____	_____
Healthcare Provider (Print Name)	Healthcare provider Signature	Office phone number	Date

Print or Stamp With Office Address