School District of Indian River County

6500 57th Street ● Vero Beach, Florida, 32967 ● Telephone: 772-564-3000 ● Fax: 772-564-3054

PHYSICIAN'S AUTHORIZATION FOR DAILY MEDICATION
SCHOOL YEAR 20___ to 20___

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 administer this physician prescribed medication or treatment.

ONE MEDICATION PER FORM

Diagnosis/ICD 10 Code: ____

Allergies: ____

Medication name: ______________________________ Dosage: ____________________________________

Route: ___________________________ Schedule: ______________________________________
(Interval Between Doses)

Time to be administered during school hours: ___________________________
(Must be time specific)

SPECIAL INSTRUCTIONS

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

Print or Stamp With Office Address