SCHOOL DISTRICT OF INDIAN RIVER COUNTY MEDICATION PERMISSION SLIP SCHOOL YEAR 20___ TO 20___

Pharmacist: Place duplicate label to prescription (bottle) here

Student Name:_____

ID #: _____ DOB: _____

Grade" _____

Allergies:_____

Medicaid number:_____

PLACE CURRENT STUDENT PHOTO HERE

KEY: A-absent D-early dismissal F-field trip L-late M-missed dose O-out of meds R-refused W-Withheld *(document reason)* **X-no school**

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
AUG	**Time/ Initials**																															
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SEPT	**Time/ Initials**																															
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JAN	**Time/ Initials**																															
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JUN	**Time/ Initials**																															
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Weekly Signature/ Date																																

SIGNATURE KEY OF PERSON ASSISTING STUDENTS WITH MEDICATION

Name:	Initials	Name:	Initials	Name:	Initials

I hereby request and give my permission for district school board personnel to assist my child with medication administration as prescribed by my child's medical provider, and in accordance with FL Statute 1006.062, the district health services manual and the approved School Health Services Plan. I understand that medical information related to the care of my student during the instructional day or while away on school sponsored field trips will be shared with school staff on a need to know basis. I also understand that this medication will be disposed of on the last day of the current school year or when expired UNLESS picked up by parent/guardian.

Parent/Guardian Signature: _____ Date: ____/____/____ Student Name: _____ Student ID: _____

I hereby request and give my permission for district school board personnel to assist my child with medication administration as prescribed by my child's medical provider, and in accordance with FL Statute 1006.062, the district health services manual and the approved School Health Services Plan. I understand that medical information related to the care of my student during the instructional day or while away on school sponsored field trips will be shared with school staff on a need to know basis. I also understand that this medication will be disposed of on the last day of the current school year or when expired UNLESS picked up by parent/guardian.

Parent/Guardian Signature: _____ Date: ____/____/____ Student Name: _____ Student ID: _____