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 DAILY MEDICATION

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 PLEASE

Routine Daily Medication

Diagnosis: _____ Allergies: _____

Medication name: _____ Dosage/Strength: _____

Route: _____ Schedule: _____
(Interval Between Doses)

Time to be administered during school hours: _____
(MUST BE TIME SPECIFIC)

SPECIAL INSTRUCTIONS

_____

_____

_____

_____

_____

_____

_____	_____	_____	_____
Physician Name (Print)	**Physician Signature**	**Office phone number**	**DATE**

(Print or Stamp With Office Address)