



## **2023-2024 Authorization for Medication**

Dear Parent/Guardian:

In order to ensure student safety and health, the Polk County Health Department has established a policy for all schools in Polk County in order for the administration of medication during school hours.

If your child must be given medication of any kind during school hours, including over-the-counter medications, you have the following choices:

1. You, or someone chosen by you, may come to school and give the medication to your child.

OR

2. You may get a copy of the Authorization for Medication form online at [www.school.glwh.org](http://www.school.glwh.org) from and take it to your child's physician, medical provider, the Health Department or a walk-in clinic. This form must be filled out and signed by the doctor/mid-level practitioner and by you. Once completed, return this form to school. Medication may be given at school only when an Authorization for Medication is on file.

OR

3. Authorization for Medication for over the counter medications is valid if signed by the parent who is ultimately responsible.

OR

4. You may choose to discuss with your doctor/mid-level practitioner a schedule for giving medication outside of school hours.

School personnel are not allowed to give any medication to students unless they have received a properly completed Authorization for Medication signed by you and your child's doctor/mid-level practitioner. The medication must be received in the original container, including your child's name.

For your convenience, a copy of the Authorization for Medication is printed on the back of this letter. Take a copy of this form with you whenever you take your child to the doctor. This authorization must be renewed at the beginning of each school year, or if your child's medication or dose changes. Extra copies are available in the school office.

Thank you for your cooperation.

# Authorization for Medication

The following section is to be completed by the **PARENT**:

<b>Grace Lutheran School, Winter Haven, FL</b>				<b>Grade</b> _____	
Child Name _____		Sex _____	Date of Birth _____		
Physician's Name _____			Phone # _____		
Address _____					
I request that my child be assisted in taking the medicine(s) described below at school by authorized persons as authorized by me and my physician (see below).					
_____		_____		_____	
Date	Parent/Guardian Signature	Home Phone	Emergency Phone		

**THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN:**

Diagnosis for which medication is given: _____
Name of Medicine: _____
Form: _____
If medicine is to be given at school at what time: _____
If medicine is to be given "When Needed" describe indication: _____
How soon can it be repeated?: _____
List significant side effects: _____
Length of time this treatment is recommended: _____

Other Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Physician's / Mid-level Practitioner's Signature

Format developed by:  
The American College of  
Allergists

Place Office Stamp Here
-------------------------