2024-2025 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 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:

Grace Lutheran School, Winter Haven, FL Grade_____

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