|  |  |  |  |
| --- | --- | --- | --- |
| Student Name: |  | Date of Birth: |  |
| Address: |  | Phone #: |  |
| List Known  ALLERGIES: |  | Teacher/Grade |  |

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| --- | --- | --- | --- |
| Please list the over the counter Non-Medical product: | | |  |
| When should this product be given: | |  | |
| Additional information: |  | | |

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| --- | --- | --- |
| **PARENT to Complete: Authorization for Health Care Provider and School Nurse to Share Information** | | |
| I authorize my child’s school nurse to assess my child as regards his/her special health care needs and to discuss these needs with my child’s physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.  As the parent or guardian of the student named above, I request that the principal or principal’s designee assist in the administration of medication/treatment prescribed for my child.  I understand that under provisions of Florida Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them. I authorize the physician to release information about this condition to school personnel. | | |
|  |  |  |
| **Parent/Guardian Signature** | **Print Name** | **Date** |

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| --- | --- | --- | --- |
| Parent/Guardian: |  | Cell: |  |
|  |  | Work |  |
| Parent/Guardian: |  | Cell: |  |
|  |  | Work: |  |