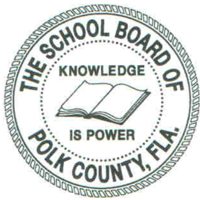

SCHOOL BOARD OF POLK COUNTY

P.O. BOX 391
BARTOW, FLORIDA 33831

(863) 534-0500

1915 SOUTH FLORAL AVENUE
BARTOW, FLORIDA 33830

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Superintendent

Dear Parent/Guardian:

In order to ensure student safety and health, the Polk County School Board has established a policy for the administration of medications 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 **an adult designated** by you in writing, may come to school and give the medication to your child. The clinic para/health contact may not be designated for this responsibility.

OR

2. You may obtain a copy of the Authorization for Medication/Treatment form from your child's school and take it to your child's medical provider .This form must be filled out and signed by the doctor/mid-level practitioner and the parent/legal guardian. Once completed, return this form to your child's school. Medication may be given at school only when an Authorization for Medication/Treatment is on file. Parents of students who require the use of an inhaler or EpiPen or require glucose testing or medication for diabetes or require pancreatic enzyme supplements should talk to their physician about adding a notation on the Authorization for Medication/Treatment that the student needs to carry the medication and self-administer.

OR

3. 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/Treatment signed by you and your child's doctor/mid-level practitioner. A new authorization form is required at the beginning of each school year and anytime a medication or dosage is changed.

ONLY an adult may transport medications to and from the school clinic. Prescription medication must be received in the current pharmacy-labeled container. Over-the-counter medication must be received in the original container labeled with your child's name. Medication required to be split must be done either at home or by the pharmacist before it is brought to school. Clinic aides are not permitted to split medication.

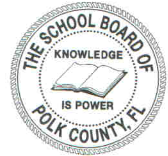
For your convenience, a copy of the Authorization for Medication/Treatment is printed on the back of this letter. Take a copy of this form with you whenever you take your child to the doctor. This authorization form may also be accessed @ www.polk-fl.net.

If you have any questions, please check with your child's school or call Polk County School Health Services at 291-5355.

Thank you for your cooperation.

Rev. 4-11

Authorization for Medication /Treatment



Revised 5-09

The following section is to be completed and signed by the PARENT:

A new authorization **must** be completed at the beginning of **each** school year or anytime a dosage is changed. All medications and/or treatment, equipment or supplies must be provided by the parent.

Child's Name ______ Last ______ First ______ Sex ______ Grade ______ Date of Birth

______ Physician's Name ______ Address ______ Emergency Phone

I hereby authorize the above named physician and Polk County Schools/Polk County Health Department staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand Polk County School District protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed, or electronic.

I request that my child be assisted in taking the medication or treatment described below at school by authorized persons as permitted by me and my physician (*see below*).

______ Date ______ Parent/Guardian Signature ______ Home Phone ______ Emergency Phone

The following section is to be completed by the PHYSICIAN:
(***ONLY ONE*** *medication or treatment per form)*

Diagnosis for which medication or treatment is given:

Name of medication or treatment: ______

Form: ______

Dose: ______

If medication or treatment is to be given at school, at what time? ______

If medication or treatment is to be given "When needed", describe indications:

______

How soon can it be repeated? ______

List significant side effects: ______

Length of time medication/treatment is recommended:

Other information:

______

______

______ Date ______ Physician's/Mid-level Practitioner's Signature

Place Office Stamp Here

Adapted from the American College of Allergists