

Pasco County Schools
Parent/Guardian Medication Administration Permission Form

I have read Pasco County Schools' *General Guidelines for Administration of Medication at School* and permission is hereby granted to _____ Pasco County Schools' (Name of school)

trained personnel to administer the following medication to:

(Student's name) (Student #) (Grade) (DOB)

for the treatment of _____.
(Health condition)

Name of prescribing Health Care Provider: _____

Known Allergies: _____

Name of medication: _____

Dose of medication: _____ Route of medication: _____ Time to be given at school: _____

Special instructions (including reasons for which medication must be administered during the school day or at after school activities): _____

Possible reactions / side effects: _____

I hereby authorize designated Pasco County Schools' 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 Pasco County Schools 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 hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this authorization form. I understand that I am responsible to furnish/restock all supplies and medications and that any unused medication that is not retrieved by me at the end of the school year will be destroyed. I acknowledge that I am the parent/guardian of the student listed above and I have the rights and authority set forth in the Parent's Bill of Rights and related laws, and I further acknowledge that I have had the opportunity to review the district's resources identifying my rights (including the notices located at https://www.pasco.k12.fl.us/ssps/page/parent_notices, and pursuant to the Parent's Bill of Rights, Chap.1014, Fl. Stat.), and my acknowledgement and my consent is indicated by my signature below. I understand that the form must be completed each school year.

(Signature of Parent / Guardian) Date: _____

Note: Give parent copy of *General Guidelines for Administration of Medication at School*