

# Authorization for Medication/Treatment



**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.

Revised 8-19

Non Pitit la _____	Siyati _____	Non _____	Seks _____	Klas _____	Dat Nesans _____
Non dokte-a _____	Adres _____	Nimewo Telefon anka ijans _____			
<p>Mwen sevi ak dokiman sa-a pou otorize Dokte mwen site piwo-a e Lekol Piblik yo/Depatman Sante Piblik Florid e manm pesonel ki travay pou yo nan nan Zon Pok la pou pataje resiprokman antre yo enfomasyon medikal dosye ya elektwonikman tou sou etidyan an kesyon-an ki gen non li site piwo-a nan fom sa-a. Pataj sou enfomasyon sante etimedikaman ki nesese nan moman etidyan-an nan lekol la. Mwen rekonet ke Distri Eskole Pok la va pwoteje e sekirize privatsite enfomasyon medikal etidyan-an jan Lwa Federal e Eta yo egzije sa sou tout fom tankou, pou site skek ladan yo, men gen lot toujou, oral, ekri, faks, ou elektwonik.</p> <p>Mwen mande pou pesonel otorize yo bay pitit mwen-an ed pou li pran medikaman ou tretman ki dekri pi-ba-a, sou pesmisyon Doke mwen e pemisyon pam (gade pi ba-a-see below).</p>					
_____	_____	_____	_____	_____	_____
Dat	Parak Paran/Gadyen	Telefon Kay la	Telefon an ka		

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

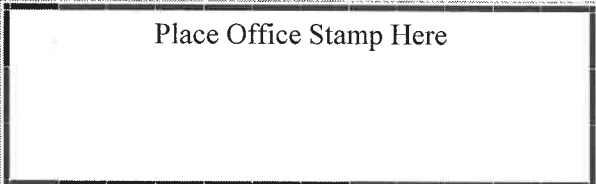
*(ONLY ONE medication or treatment per form)*

Diagnosis for which medication or treatment is given:
Name of medication or treatment:
Form:
Dose:
Route:
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:**

<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> <hr style="border: none; border-top: 1px solid black;"/>
---

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



*Adapted from the American College of Allergists*