School District of Indian River County

PHYSICIAN'S AUTHORIZATION FOR AS NEEDED OR EMERGENCY MEDICATION
SCHOOL YEAR 20___TO 20___

Name of Student _____ DOB _____

The above-named student is under my medical supervision for the diagnosis described below. I have prescribed the following medication/treatment. I am aware that trained non-medical staff may assist the student with this physician prescribed medication or treatment.

ONE MEDICATION PER FORM

Diagnosis/ICD 10 Code: _____

Allergies: _____

Medication name: _____ Dosage: _____

Route: _____ Schedule: _____
(Interval Between Doses)

(_____)

SPECIFY SYMPTOMS ABOVE FOR WHICH THE STUDENT IS TO TAKE THE MEDICATION
(i.e. cough, wheezing, shortness of breath, headache, orthodontic discomfort, etc.**)**

For Asthma Inhalers or Epinephrine Auto-Injectors ONLY

Student has been instructed in proper use of an asthma inhaler Yes ☐ No ☐

Student has been instructed on how to self-administer an auto-injector Yes ☐ No ☐

Student is competent to carry and self-administer this medication at school and while away on school sponsored activities Yes ☐ No ☐

SPECIAL INSTRUCTIONS

_____

_____

_____	_____	_____	_____
Healthcare Provider (Print Name)	Healthcare provider Signature	Office phone number	Date

Print or Stamp with Office Address