3221 Sand Lake Rd, Longwood, FL 32779 | Phone: (407) 869-8882 | Fax: (407) 637-5309 l www. pacebrantley.org

Pace Brantley Clinic Packet

Pace Brantley Clinic Packet-Student Medication Authorization (1 of 2)

Student Name _____

Date of Birth _____ Grade_____ Sex: Male Female

Address _____
Street City State Zip Code

The following section is to be completed by the prescribing physician prior to the administration of medications. The following medication(s) is necessary to be given in school and during school sponsored activities, I am aware that this medication may be administered by non-medical personnel.

Diagnosis for which medication will be required in school:

Medication: _____ Strength: _____ Dosage: _____

Route: Oral Topical Inhaled Other (please describe) _____

Frequency:
If medication is to be given at a *schedule time*, what time? _____

If medication is to be given *when needed*, when would it be indicated?_____
--How many times can it be given?_____
--How soon can it be repeated after each dose? _____

Length of time (duration) medication is ordered:_____

If applicable, is the student authorized to carry and self-administer medication? Yes No

Is middle or high school student authorized to self-administer OVER THE COUNTER medication? Yes No

List any significant side effect to the medication:

_____
Physician Name, Address and Phone

_____
Physician Signature Date

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Pace Brantley Clinic Packet-Student Medication Authorization (2 of 2)

Student Name: _____Grade:_____

The following section is to be completed by the parent/guardian:

I hereby grant permission to Pace Brantley Preparatory School and its designees to assist in the administration of the above prescribed medication to my child while in school and during school sponsored activities (FS232.46), (SC5.62). It is my responsibility to provide the school with a new medication authorization form if and when these orders change. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication act as an ordinarily prudent person would under the same or similar circumstances.

_____

Parent/Legal Guardian Name Parent/Legal Guardian Signature Date

_____

Parent/Legal Guardian Best Contact Number

_____

Parent/Legal Guardian Email

**All prescribed medication to be administered at school must be received in the original containers
**This authorization is valid for 12 months only and must be renewed each school year.

Please contact the school clinic with any questions 407-869-8882