UF UNIVERSITY of FLORIDA

Department of Pediatrics
Division of Pulmonary Diseases

PO Box 100296
Gainesville, FL 32610-0296
352-273-8380
352-273-8897 Fax

Authorization for Medications to be Taken During School Hours

Student's Name:	**DOB**

I request that my child be assisted in taking the medicine(s] described below at school by authorized persons or permitted to medicate herself/himself as authorized by me and my physician.**I permit school staff to discuss this medication with the UF Pediatric Pulmonary staff or the child's pharmacy.**

Parent Signature **Date**

Diagnosis for which medication is given:	
Name of medication	
Form:	
Dose:	
Time medication is to be given	
Indications for unscheduled medication	
Frequency	
Is child authorized to self medicate?	
Significant side effects of medication	
Length of time this treatment is needed	

Physician Signature **Date**