



SCHOOL BOARD OF POLK COUNTY

P.O. BOX 391 BARTOW, FLORIDA 33831 1915 SOUTH FLORAL AVENUE BARTOW, FLORIDA 33830

(863) 534-0500 • SUNCOM 515-1321 • FAX (863) 534-0705

Board Members

CHAIRMAN
JIM NELSON
DISTRICT 2

FRANK J. O'REILLY
DISTRICT 1

ROBERT S. MACEY
DISTRICT 3

BRENDA C. REDDOUT
DISTRICT 4

ANDREA WHITELEY
DISTRICT 5

LARRY PEACOCK
DISTRICT 6

C. J. ENGLISH, III
DISTRICT 7

WESLEY BRIDGES
General Counsel

Administration
JIM THORNHILL
Superintenders of Schools

Dear Parent/Guardian:

In order to ensure student safety and health, the Polk County School Board has established a policy for the administration of medications during school hours.

If your child must be given medication of any kind during school hours, including over-the-counter medications, you have the following choices:

You, or an adult chosen by you, may come to school and give the medication to your child.

OR

- 2 You may get a copy of the Authorization for Medication form from your child's school and take it to your child's physician, medical provider, the Health Department or a walk-in clinic. This form must be filled out and signed by the doctor/mid-level practitioner and the parent/legal guardian. Once completed, return this form to your child's school. Medication may be given at school only when an Authorization for Medication is on file.

OR

- 3 You may choose to discuss with your doctor/mid-level practitioner a schedule for giving medication outside of school hours.

School personnel are not allowed to give any medication to students unless they have received a properly completed Authorization for Medication signed by you and your child's doctor/mid-level practitioner. **ONLY** an adult may transport medications to and from the school clinic. The medication must be received in a pharmacy labeled/original container, labeled with your child's name. Medication required to be split, must be done either at home or by the pharmacist before the medication is brought to school.

For your convenience, a copy of the Authorization for Medication is printed on the back of this letter. Take a copy of this form with you whenever you take your child to the doctor.

If you have any questions, please check with your child's school or call Polk County School Health Services at 291-5355.

Thank you for your cooperation

Authorization for Medication



The following section is to be completed and signed by the PARENT:

| | | | |
|------------------|---------|-----------------|---------------|
| _____ | | _____ | |
| Child's Name | School | Grade | |
| _____ | _____ | _____ | _____ |
| Last | First | Sex | Date of Birth |
| _____ | | () _____ | _____ |
| Physician's Name | Address | Emergency Phone | |

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons as authorized persons as authorized by me and my physician (see below).

| | | | |
|-------|---------------------------|------------|-----------------|
| _____ | _____ | () _____ | () _____ |
| Date | Parent/Guardian Signature | Home Phone | Emergency Phone |

The following section is to be completed by the PHYSICIAN:

Diagnosis for which medication is given:

Name of medication:

If medicine is to be given at school, at what time?

If medicine is to be given "When needed", describe indications:

How soon can it be repeated?

List significant side effects:

Length of time this treatment is recommended:

Other information:

Date _____ Physician's/Mid-level Practitioner's Signature _____

Format Developed by: the American College of Allergists

Place Office Stamp Here