AUTHORIZATION FOR MEDICATION
Lake Wales Charter Schools, Inc.

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

Please Print Legibly:

Child's Name: _____ ____ _____ _____

Last **First** **Sex** **Grade** **Date of Birth**

_____ _____

Physician's Name **Address** **Emergency Phone**

I hereby authorize the above named physician and Lake Wales Charter Schools staff to reciprocally release verbal, written or faxed protected health information (PHI) regarding the above named child for the purpose of giving necessary medication while at school. I understand PHI is confidential and is protected by the Health Insurance Portability and Accountability Act (HIPAA).

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons as permitted 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:

Please Print Legibly:

Diagnosis for which medication is given: _____

Name of medication: _____

Form: _____

Dose: _____

Route: _____

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**

Place Office Stamp Here