AUTHORIZATION TO CARRY MEDICATION(S) PERMITTED BY FLORIDA STATUTE 1002.20:
ASTHMA INHALERS, EPINEPHRINE AUTO-INJECTORS, DIABETES SUPPLIES OR PANCREATIC ENZYMES

Date: _____

Student Name: _____ DOB: _____

School: _____ Grade: _____

It is medically necessary for this student to carry his/her medication and/or supplies while in school as permitted by Florida Statute 1002.20. This student is capable of self-management and administration of the following medication and/or supplies.

This authorization is valid for the current school year only (if for specific dates, please specify).

Medication and/or Supplies: _____

_____

Dosage/Instructions: _____

_____

Diagnosis: _____

_____	_____	_____	_____
Physician Signature	**Physician Name**	**Phone Number**	**Date**

I have read and understand the waiver of liability statements on the Authorization for Medication (Page 1) and feel that my child is capable of self-management and administration of the above medication/supplies.

_____	_____	_____	_____
Parent Signature	**Parent Name**	**Phone Number**	**Date**

*****For staff use only*****

The student has demonstrated that he/she is responsible in the use and storage of the above medication.

_____	_____	_____	_____
FDOH RN Signature	**FDOH RN Name**	**Phone Number**	**Date**