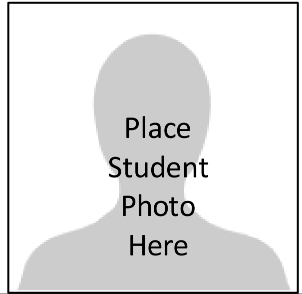
AUTHORIZATION FOR ADMINISTRATION OF PRESCRIBED TREATMENT

Ina A. Colen Academy
5080 SW 66th Ct. Rd. Ocala, Fl 34474
Contact (352) 304-6787 info@iacafl.org



Request Beginning (Date): ______________________ To: __________________________
Not to exceed one (1) school year — Form must be renewed *each* school year

Student: ____________________________________ Student #: ______________ DOB: ______________

Parent/Guardian: ____ Phone: __________________

Health Condition(s) Requiring Treatment/Pertinent History:
____
____
____

PHYSICIAN AUTHORIZATION/ORDER (TO BE COMPLETED BY THE PRESCRIBING PHYSICIAN)

1. **Prescribed treatment can only be administered or performed at school when failure to receive such treatment could jeopardize a student's health.**
2. **The Physician Authorization/Order and Legal Guardian Authorization segments of this form must be completed and signed prior to the execution of the prescribed treatment.**

The above-named student is under my medical supervision. I have prescribed the following treatment:
____
____

Equipment/Supplies necessary for treatment: ____

Reason(s) for treatment: ____

Possible adverse reactions or complications of prescribed treatment:
____
____

Physician Name: ____________________________________ Physician Phone: ____________________
PLEASE PRINT

Physician Address: ____

Physician Signature: ______________________________________ Date: __________________

LEGAL GUARDIAN AUTHORIZATION:

I hereby authorize the administration of treatment described above to my child by the After School Program Staff or other appropriately trained non-medical personnel. I understand that I must supply the school with the equipment/supplies listed above. I release the Ina A. Colen Academy and related personnel from liability in connection with the administration of above treatment and authorize them to contact the prescribing physician as may be necessary.

Parent/Guardian Signature: ____________________________________ Date: __________________