IMPACT TALLAHASSEE
PRESCHOOL ACADEMY COMMUNITY THERAPY

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1725 Hermitage Blvd.
Tallahassee, FL 32308

# MEDICATION PERMISSION FORM

I hereby certify that it is medically necessary for:

**Name:** _____ **Date of Birth:** _____

to be given the medication listed below during the camp day, including when he/she is away from school on field trips. Without this medication, he/she will not be able to attend school. Signed form is necessary for all the following: medicines given by mouth, inhaled, by nebulizer, on skin, patch, injection, etc.) Only FDA-approved medicines will be accepted.

Name of Medication: _____

Reason for Medication (Diagnosis): _____

Dosage to be given: _____ How (mouth, injection, etc.): _____

Time(s) administered: _____ Allergies: _____

Beginning Date: _____ Ending Date: _____

Amount of Liquid or Count of Pills: _____

**Doctor's Name:** _____ **Phone:** _____

Prescription and non-prescription medication shall come in the original container and shall be labeled. Changes in the medication times or dosage can only be made by written prescription from the physician, which may be faxed to school personnel.

I hereby consent to protected health information being used and disclosed to carry out treatment, payment, or health care operations of my child. I understand that IMPACT Tallahassee may need to give and receive protected health information pertaining to the management of my child's medical condition with the health care provider listed above, and I hereby authorize the exchange of this information as needed to carry out the treatment, payment, or health care operations of my child. I also give permission for the information on this form to be reviewed and utilized by the staff of this school and any health care professionals associated with this school. I hereby authorize IMPACT Academy of Tallahassee, Florida, and their officers, employees, contractors, and agents to assist my child with medication administration and/or to supervise my child's self- administration of medication(s) as directed by his/her Prescribing physician(s).

I acknowledge and agree that non-health professionals may assist my child with medication administration. I hereby release, indemnify, and hold harmless IMPACT Tallahassee and any of their officers, employees, contractors, and agents any and all lawsuits, claims, demands, expenses, and actions against them associated with their activities assisting my child with medication administration and/or supervising my child's self-administration of medication(s), provided they follow the physician's orders on record. I also hereby agree to indemnify and hold IMPACT Tallahassee and their officers, employees, contractors, and agents harmless from any and all lawsuits, claims, demands, expenses, and actions against them arising from harm to any person caused by my child's actions with regards to a self-carried medication.

Parent Printed Name _____

Signature _____ Date: _____