MEDICATION/TREATMENT AUTHORIZATION FORM -- ALLERGY

Name:__ DOB:

►►To be completed by PARENT/GUARDIAN--Parent/Guardian Permission◄◄

It is my responsibility to notify the school if and when these orders change

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►►To be completed by PRESCRIBING PHYSICIAN/Healthcare Provider (HCP)--MUST BE LICENSED in the State of Florida◄◄

A ALLERGIES: _____

►►STEP 1: TREATMENT◄◄

Symptoms

☐ ☐ A

☐

s order is only effective fo year: 20___ 20_____

DIAGNOSIS: _____

ype of Allergy

❑ Medication
medicatia

❑ Environmental Allergen ❑ /Stings

Allergy

❑ ❑
❑ ❑
❑ ❑
❑

❑ Life-Threatening ALLERGIES:_____

❑ ❑

Is medication required immediately after exposure to any allergy producing substance?