



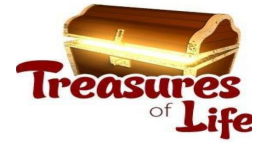
# Treasures of Life Academy

(863)299-2100 or (863)595-6525

1202 Havendale Blvd N.W. Winter Haven, FL 33881

Executive Director: Mrs. Kim Toney

Website: [www.treasuresoflifeacademy.org](http://www.treasuresoflifeacademy.org)



## Parental Authorization for Prescriptions

Student \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
Treasures of Life Academy \_\_\_\_\_  
School \_\_\_\_\_ Date \_\_\_\_\_ Grade \_\_\_\_\_  
\_\_\_\_\_  
Educator \_\_\_\_\_ Date of Birth \_\_\_\_\_

	Medication	Active Ingredient	Dosage	Medical Purpose	Possible Side Effects
Ex	Amoxicot	Amoxicillin	250mg	ear infection	severe rash, jaundice, hives, etc.
1					
2					

I hereby give my permission for \_\_\_\_\_ to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication and to personally bring the above medication in the original container appropriately labeled by the pharmacy or physician stating the child's name, name of the prescribing doctor or dentist, name of medication, dosage, and time to be given. I hereby request that my child be given the above medication while in school and away for official activities. I understand that non-medical personnel may give the medication. I give permission for appropriate personnel to communicate with my child's physician and/or pharmacist in the matters related to medication and health supervision. I understand that administration will not begin until this form is on file and personnel have received instruction concerning administration of medication.

I understand and agree that Treasures of Life Academy, its officials, and employees are not responsible for any effects of the medication administered. I understand I must notify the school in writing of any changes in my child's condition. I further understand that I am responsible for ensuring that the medication is safely delivered to the appropriate office officials and for getting refills of the medication as indicated.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

State of Florida, County of Polk

I hereby certify that the foregoing was executed before me this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

\_\_\_\_\_  
Notary Public, State of Florida