

# Otorizasyon pou bay Medikaman /Tretman



## Se PARAN elèv la ki dwe ranpli epi siyen pati pi ba a:

Yo dwe ranpli yon nouvo otorizasyon nan koumansman **chak** ane lekòl oswa nenpòt ki lè yo chanje dòz medikaman an. Paran an dwe bay tout ekipman ki akonpaye medikaman ak/oswa tretman yo.

Revize 5-09

|                             |               |             |                   |
|-----------------------------|---------------|-------------|-------------------|
| <u>Non Timoun nan</u>       | <u>Siyati</u> | <u>Non</u>  | <u>Seks</u>       |
| <u>Non Doktè a</u>          | <u>Adrès</u>  | <u>Klas</u> | <u>Dat Nesans</u> |
| <u>Telefòn pou ka Ijans</u> |               |             |                   |

Nan deklarasyon sa a mwen otorize doktè ki gen non l pi wo a epi ekip lasante nan Lekòl Polk la/ak Depatman Lasante nan Kanton Polk la pou yo devwale youn bay lòt enfòmasyon sante vèbal, ekri, pa faks oswa pa mwayen elektwonik, konsènan elèv ki gen non l pi wo a, nan objektif pou yo ba li medikaman oswa tretman nesèsè pandan l lekòl la. Mwen konprann distri lekòl nan Depatman Polk la pwoteje enfòmasyon sante elèv, jan lalwa federal ak lwa nan Eta Florid mande sa, e nan tout fòm dosye tankou, men se pa sa sèlman, dosye ki gen enfòmasyon oral, ekri, fakse oswa elektwonik.

Mwen mande pou moun ki otorize pou sa nan lekòl la ede pitit mwen an nan ba li medikaman li oswa tretman li, jan mwen menm ak doktè mwen pèmèt sa (*gade pi ba a*).

|            |                                      |                         |                             |
|------------|--------------------------------------|-------------------------|-----------------------------|
| <u>Dat</u> | <u>Paraf Paran/Responsab Elèv la</u> | <u>Telefòn Lakay la</u> | <u>Telefòn pou ka Ijans</u> |
|------------|--------------------------------------|-------------------------|-----------------------------|

The following section is to be completed by the PHYSICIAN: (TSe DOKTÈ a ki dwe ranpli pati pi ba a): (**ONLY ONE** medication or treatment per form)

Diagnosis for which medication or treatment is given:

Name of medication or treatment:

Form:

Dose:

If medication or treatment is to be given at school, at what time?

If medication or treatment is to be given "When needed", describe indications:

How soon can it be repeated?

List significant side effects:

Length of time medication/treatment is recommended:

### Other information:

Place Office Stamp Here

\_\_\_\_\_  
Date Physician's/Mid-level Practitioner's Signature

*Adapted from the American College of Allergists*