

HEALTH SERVICES

AUTHORIZATION TO ASSIST IN THE ADMINISTRATION OF MEDICATION/TREATMENT

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
School: \_\_\_\_\_ Teacher/Grade: \_\_\_\_\_

Allergies: \_\_\_\_\_

NURSING SERVICES AND MEDICATION/TREATMENT ORDER

ALL INFORMATION MUST MATCH THE PRESCRIPTION LABEL! All medication must be properly labeled and in original containers. Complete one form for each medication/treatment to be administered. A new form must be completed if the dosage of a medication changes at any time.

Nursing services are recommended for the care of this student during the school day.

It is necessary for the following medication/treatment to be given in school and during school sponsored activities. I am aware that non-medical personnel may administer this medication/treatment.

Name of medication/treatment: \_\_\_\_\_ Amount (Dosage): \_\_\_\_\_
Time to be given: \_\_\_\_\_ Date to start: \_\_\_\_\_ Date to end: \_\_\_\_\_
Health condition requiring medication: \_\_\_\_\_
Possible side effects: \_\_\_\_\_
Special instructions: \_\_\_\_\_
Physician ordering medication: \_\_\_\_\_ (please print)

Physician's address: \_\_\_\_\_
Physician's phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician's signature: (required for all medications) \_\_\_\_\_ Date: \_\_\_\_\_

PARENT to Complete: Authorization for Health Care Provider and School Nurse to Share Information

I authorize my child's school nurse to assess my child as it relates to his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually. As the parent or guardian of the student named above, I request that the principal or principal's designee assist in the administration of medication/treatment prescribed for my child. I understand that under provisions of Florida Statute 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administering such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them. I authorize the physician to release information about this condition to school personnel.

Parent/Guardian Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

EMERGENCY MEDICATION (INHALER/EPINEPHRINE)—Florida Statute 1002.20

Florida law states a student may carry a metered dose inhaler or epinephrine auto-injector on his/her person and self-administer while in school with approval from his/her parents and physician.

The above named child may carry and self-administer his/her emergency medication.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_
Physician's Signature: (required) \_\_\_\_\_ Date \_\_\_\_\_