ST. JOHNS COUNTY SCHOOL DISTRICT
HEALTH SERVICES

OVER-THE-COUNTER NON-MEDICAL

Student Name: ______________________ Date of Birth: ______________________

Address: ______________________ Phone #: ______________________

List Known ALLERGIES: ______________________ Teacher/Grade ______________________

Please list the over the counter Non-Medical product:	
When should this product be given:	
Additional information:	

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 regards 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 Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating 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.

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Parent/Guardian Signature **Print Name** **Date**

Parent/Guardian: ______________________ Cell: ______________________

______________________ Work ______________________

Parent/Guardian: ______________________ Cell: ______________________

______________________ Work: ______________________