ST. JOHNS COUNTY SCHOOL DISTRICT
AUTHORIZATION TO ASSIST IN THE ADMINISTRATION OF MEDICATION/TREATMENT

Student's Name: _____ **Date of Birth:** _____

School: _____ **Grade:** _____ **Teacher/Homeroom:** _____

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.

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 (i.e., may carry epi-pen/Glucagon on person): _____

_____

Physician ordering medication: _____
(Print)

Physician's address: _____

Physician's phone: _____ **FAX:** _____

Physician's signature: (required for all medications) _____

THIS SECTION FOR PARENT/GUARDIAN TO COMPLETE:

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.

_____	_____	_____
Parent/Guardian Signature	Work/Home/Cell Phone	Date

ASTHMATIC STUDENTS: POSSESSION OF INHALERS—Florida Statute 1002.20

*Florida law states an asthmatic student may carry a prescribed metered dose inhaler on his/her person while in school with approval from his/her parents **and** physician.*

The above named child may carry and self-administer his/her metered dose inhaler.

Parent/Guardian Signature: _____ Date: _____

Physician's Signature: (required) _____ Date: _____

St. Johns County School District Health Services

Parent Permission for Student to Self-Administer Non-Prescription Medication

School Board Policy 5.15 – Administration of Medication During School Hours, states that "all prescription and non-prescription medication administered by the school at the elementary, middle and high school level must be directed by a physician who has determined that a student's health and well-being requires medication during school hours. All non-prescription medication in the possession of students at the middle and high school not administered by the school requires written permission from the parent to the school."

To comply with **School Board Policy 5.15,** parents/guardians are responsible for obtaining the Medication Authorization Form to be filled out by the physician if medication will be given by the school. For those students carrying Non-prescription; Non-emergency medications, the parent/guardian is responsible for completing the Parental Permission Form at the bottom of this letter.

School Board Policy 5.15 – Administration of Medication During School Hours, states that a student at the middle and high school level may carry a Non-prescription; Non-emergency medication on his/her person while in school with approval from his/her parent/guardian. **Over-the-counter medications must be in the original container.**

I give permission for the below named child to carry and self-administer his/her own Non-prescription; Non-emergency medication. I understand that my child may not share his/her medication under any circumstance and that a copy of this permission form must accompany the stated medication. I understand that if there is inappropriate behavior or a safety risk, ***the privilege*** of carrying his/her medication will be rescinded.

Student Name _____ Grade _____ Homeroom _____

Name of Non-prescription; Non-emergency medication _____

Reason for medication _____

_____

_____ _____ _____

Parent/Guardian Signature Parent/Guardian Printed Name Date

I understand that I am not to share my medication under any circumstance and that a copy of this permission form must accompany the above medication.

_____ _____ _____

Student Signature Student Printed Name Date

**Revised July, 2011*