MEDICATION/TREATMENT AUTHORIZATION FORM

Name:____ **DOB:**____________ **SCHOOL:** _________________________________

►►**To be completed by PARENT/GUARDIAN--Parent/Guardian Permission**◄◄

I hereby grant permission to the principal or his/her designee of ________________________________ School to assist in the administration of the prescribed medication and/or treatment to my child while in school and away from school while participating in official school activities (F.S. 1006.062). **It is my responsibility to notify the school if and when these orders change**. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication and/or treatment where the person administering such medication and/or treatment acts as an ordinarily reasonably prudent person would under the same or similar circumstances.

Parent/Guardian Name: ____ Relationship: ___________________

Emergency Phone: ___________________________ Home Phone: __________________________ Work Phone ________________________

Address: ____

Parent/Guardian Signature: ____ DATE: __________________

Parent/Guardian Printed Name: ____

►►**To be completed by PRESCRIBING PHYSICIAN/Healthcare Provider (HCP)--MUST BE LICENSED in the State of Florida**◄◄

A separate form MUST BE COMPLETED for each medication/treatment prescribed

The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following medication/treatment, which is necessary during school hours. I am aware that trained non-medical staff may administer this physician prescribed service. **This order is only effective for the school year: 20_______ -- 20_______**

DIAGNOSIS (for THIS medication/treatment): ____

ALLERGIES: ____ **Treatment:** _________________________

Name of Medication: _____________________________________ **STRENGTH (i.e. mg/tab):** _______________

INSTRUCTIONS to give: **Amount (i.e. No. of tablets or teaspoons):** ___________________ **TIME:** _____________

Frequency (i.e. every 6 hrs PRN): ___________________________ **Duration:** __________

ROUTE: ☐ ORAL ☐ Inhaled ☐ Topical ☐ Subcutaneous ☐ I.M. ☐ Other (describe): ____________________

Possible SIDE Effects (MUST BE COMPLETED): ____

Time medication given at home (if applicable): ______ Other medications given at home:________________________________

- Medication EXPIRATION DATE to follow manufacturer's expiration date? ☐ Yes ☐ No
- Is medication needed during field trips? ☐ Yes ☐ No
- Is student authorized to carry and use/self-administer asthma inhaler?* ☐ Yes ☐ No
- Is student authorized to carry and use/self-administer epinephrine auto-injector?* ☐ Yes ☐ No
- Is student authorized to carry and use/self-administer pancreatic enzymes?* ☐ Yes ☐ No

***(physician must provide education on use)**

Other Information: ____

Licensed Physician/HCP's Name: ____ Credentials/Specialty ______________________

Address: ____ Telephone:______________________ FAX:______________________

Licensed Physician/HCP's Signature: ____ Date: ______________________

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Instructions: For medication/treatment administration during school hours-- see Requirements below.

State regulations and school board policy require that you and your child's doctor must provide written permission for any prescribed medications, including over-the-counter (OTC) medications and/or medical treatments.

The administration of prescribed medications/treatments to a student during school hours will only be permitted when the failure to do so would jeopardize the health of the student, the student would not be able to attend school if the medication or treatment were not made available during school hours, or if the child is disabled and requires medication to benefit from his/her educational program. (CCPS Policy 5330)

- The Medication/Treatment Authorization Form on the reverse side of this document must be completed **ENTIRELY** and accompany any medication (either prescribed or OTC) to be given to your child at school. **Both a parent/legal guardian and the prescribing doctor/HCP MUST SIGN the form**. Staff will not administer medication to your child without this **written consent**. The section completed by the prescribing doctor **MUST BE LEGIBLE** or this form will be invalid.

- **Prescribed Medications:** must be hand carried by parent/guardian/authorized adult to the health clinic in a container with the original, unaltered prescription label attached. The label must display all legal information required for a pharmacist to dispense a prescription medication such as valid issue and expiration date, patient name, the licensed prescriber's (doctor/HCP) name, medication name, dose , and instructions for administration.

****The medication in the container must match the label and all label information must match the Medication/Treatment Authorization Form on the reverse side of this document.**

****DO NOT SEND MEDICATIONS TO SCHOOL WITH YOUR CHILD--this is a violation of policy and may result in discipline.**

- **Over-the-counter (OTC) Medications:** must be hand carried by parent/guardian/authorized adult to the health clinic in the original, unopened store-issued container labeled with the student's full name, date of birth, and the dosage prescribed by the doctor written legibly.

- **The medication brought to the school health room must match the prescribed medication amount**. For example, if the prescribed amount is ½ tablet, then it is the responsibility of the pharmacy/parent to cut the tablets.
- ALL MEDICATION will be counted by the parent/guardian/authorized adult, verified by health clinic staff, and documented on the appropriate forms/electronic record.
- Albuterol, Asthma Inhalers, and Epinephrine Auto-Injectors must be delivered in the original box with the pharmacy label. Two pharmacy labels are required for boxes containing two Epinephrine Auto-Injectors.
- The RN/LPN at your child's school may need to call the prescribing doctor's office for medication/treatment clarification. Parents/guardians must provide contact information for their child's doctor/HCP using the student Emergency Card which must be completed and updated every year.
- A separate Medication/Treatment Authorization Form is required for each medication; a new Medication/Treatment Authorization Form is required every school year and for any order changes.
- Any medications not picked up at the end of the school year or when a medication is discontinued-will be discarded.