ST. JOHNS COUNTY SCHOOL DISTRICT

AUTHORIZATION TO ASSIST IN THE ADMINISTRATION OF MEDICATION/TREATMENT

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

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

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 (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) _____ **Date** _____

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: _____