REGULAR & SPECIAL EDUCATION - GIFTED & AUTISM CENTER / PRE-K3 TO 12TH GRADE

SOUTH FLORIDA SCHOOL OF EXCELLENCE

DETERMINATION I INTEGRITY I PERSEVERANCE

MEDICAL AUTHORIZATION FORM

Student _____ DOB / / Allergies _____

Name of Medication_____ Dose___Time _____

Route ☐by mouth ☐inhaled ☐injection ☐other:_____

Reason to be administered _____

Special instructions _____

I authorize the principal or principal's designee to assist in the administration of the medication for my child (named above). I certify that the prescribed medication is in its **original container** and that it is necessary, according to my physician's instructions, for this medication to be provided during the school day, including when my child is away from school property on official school business understand this **medication will be given only according to the directions on the label as prescribed by the doctor**. Further, I agree to waive any claims of liability that may arise against any school personnel relative to the administration of medication to my child according to these directions**. I further understand that, at the end of the school year, it will be my responsibility to pick- up any unused medication by the last day of the school year, otherwise the school will dispose of the medication.**

____ /____ /____ _____

Date Signature of Parent/Legal Guardian Parent/Legal Guardian Phone #

I have determined that it is necessary for this medication to be provided during the school day for the above named child.
(If you determined the child needs to self-carry this medication, please also complete the section at the bottom of this form.)

_____ /____ /____ _____ _____

Date Signature of Health Care Provider Provider Phone #

STUDENTS WHO ARE AUTHORIZED TO SELF CARRY MEDICATION (Epinephrine, inhalers, diabetic supplies, and pancreatic enzymes)

My child is required to self-carry this medication during the school day. I understand this means my child will be self-administering this medication and the school staff is not responsible for monitoring the administration. I understand that I am responsible for ensuring that my child has this medication during the school day, including when the student is away from school property on official school business. I will ensure the medication my child carries is properly labeled and not expired.

_____ /____ /____ _____

Date Signature of Parent/Legal Guardian

I understand that I am to self-carry my medication and to determine when I need to use the medication. I will not allow any other student to use my medication. I will notify an adult of any symptoms I experience during the school day.

_____ /____ /____ _____

Date Signature of Student

It is necessary for this child to self-carry this medication during the school day. The child is knowledgeable of when and how to use the medication.

_____ /____ /____ _____ _____

Date Signature of Health Care Provider Provider Phone #

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MEDICATION GUIDELINES

A. All Medication to Include Over the Counter Medications

The following are guidelines for the administration of medication by school personnel:

1. The principal or a trained designee may administer medication to a student while at school provided that for each medication, the student's parent or guardian shall provide to the school principal a written statement which shall grant the principal or his designee the permission to assist in the administration of each medication and which shall explain the necessity for the medication to be provided during the school day, including when the student is away from school property on official school business. The school principal or the trained school staff designee shall be allowed to assist the student in the administration of such medication.

2. All medication is to be brought to the school by a Parent or Legal Guardian.

3. All medications to be administered by school personnel shall be **received, counted** and **stored** in original containers. When a medication dose is given to a student, it **must be recorded**. If dosage is not recorded, it will be assumed that the student did not receive the required dose. When the medication is not in use, it shall be stored in its original container in a secure fashion **under lock and key** in a location designated by the principal.

4. Medication Administration Authorization forms must be completed and **signed by parent or guardian and physician** for each medication given and each time any changes occurs

B. Self-Carry Medication

Once a “Permission for Medication Administration Authorization” form is completed by the parent, student and physician indicating the need for the student to self-carry a medication is on file at the school, the student may carry the following medications: rescue inhaler, epinephrine, diabetic supplies, and pancreatic enzymes.