CALHOUN COUNTY DISTRICT SCHOOLS
FLORIDA DEPARTMENT OF HEALTH
CALHOUN COUNTY SCHOOL HEALTH SERVICES
PARENTAL AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
(FILE IN CUMULATIVE FOLDER FOR SEVEN YEARS, ONE FORM FOR EACH MEDICATION)

ADMINISTRATION BY SCHOOL PERSONNEL ALLERGIES:_____
(To be completed if parent desires school to be responsible for student's medication.)

STUDENT'S NAME:_____DOB:_____GRADE:_____TEACHER:_____
Last First M.I.

As parents/guardians of the student named above, we/I request the principal/principal's designee administer the medication described below to our/my child. NO MEDICATIONS/TREATMENTS SHALL BE ADMINISTERED WITHOUT THE COMPLETION OF THIS FORM AND SIGNATURE OF THE PARENT/GUARDIAN.

Name of Medication:_____Amount/Dosage:_____

Time to be given:_____Date to Start:_____Date to End:_____

Health condition requiring medication:_____

Special Instructions:_____

Possible side effects:_____

Name of Physician Prescribing Medication:_____ Phone:_____

We/I understand that under provision of Florida Statute 1006.062, school personnel cannot be held liable for reactions or effects from the administration of the medication. We/I also grant permission for school personnel to contact the physician if there are questions or concerns about the medication. It is legally understood that the school is not legally obligated to administer medication to my child and; therefore, I agree to hold the school district, its employees and the school health personnel free from any and all responsibility for the results of such medication or the manner in which it is administered. We/I have read the guidelines and agree to abide by them.

_____/_____/_____Date:_____
Parent/Guardian Signature Best phone number to be reached Other Number

SELF-ADMINISTRATION OF MEDICATION
To be completed by parent and physician. If any medication must be self-administered (inhalers, allergic reaction medication, CF enzymes) a written order must be received by a physician stating the need for the medication.

Student's name: _____Date:_____Grade/HR:_____
Last First M.I.

Name of medication:_____ Amount/Dosage:_____

Physician's Signature:_____ Date:_____

Provider Office/Stamp:_____

**********GUIDELINES**********

NOTE: Whenever possible, medication schedules should be arranged so all medication is given at home. Only school employees that completed training by the school nurse may administer medications to students at school.

1. ***Medication must be delivered to the school by the parent in the original container and the above permission form must be signed by the parent/guardian.***
2. The label must indicate the student's name, medication name, physician's name, dosage and time to administer. I will obtain from the physician any specific orders for my child should the school nurse request more detailed instructions.
3. Over-The-Counter medications (such as Tylenol, antacids, cough medicine, throat lozenges, etc.) are to be provided by the parent and must be in the original manufacturer's container labeled with the student's name and parent's instructions for administration.
4. Prescribed treatments, if the medication requires special equipment for administration, the parent will supply the necessary item. The school nurse has my permission to contact the physician if there are any medical concerns about my child.
5. New parental authorization forms will be requested with any change in medication or dosage and at the beginning of each school year.
6. Medication that is discontinued, expired or not picked up at the end of the school year by the parent will be **destroyed**.
7. Medications can be given within one hour of designated time. If a dose is missed, parent should be contacted.