

# 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 Statute 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administering 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: \_\_\_\_\_