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| **HEALTH SERVICES** | | | **AUTHORIZATION TO ASSIST IN THE**  **ADMINISTRATION OF MEDICATION/TREATMENT** | | |
|  | | |  | | |
| Student Name: | |  | | Date of Birth: |  |
| School: |  | | | Teacher/Grade: |  |
|  |  | | |  |  |
| **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.*   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Na**me of medication/treatment:** | | | | |  | | | | | | **Amount (Dosage):** | | | |  | | **Time to be given:** |  | | | | | **Date to start:** | | | 08/10/2022 | | | **Date to end:** | | 05/25/2023 | | | **Health condition requiring medication:** | | | | | | | |  | | | | | | | | | **Possible side effects:** | | | |  | | | | | | | | | | | | | **Special instructions**: | | |  | | | | | | | | | | | | | | **Physician ordering medication:** | | | | |  | | | | | | | | | | | |  | | | | | (please print) | | | | | | | | | | | | **Physician address:** | |  | | | | | | | | | | | | | | | **Physician’s phone:** | |  | | | | | | | **Fax:** |  | | | | | | | **Physician’s signature: (required for all medications)** | | | | | | |  | | | | | | **Date:** | |  | |  | | | | | | |  | | | | | |  | |  | | | | | | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **PARENT to Complete: Authorization for Health Care Provider and School Nurse to Share Information** | | | | | | I authorize my child’s school nurse to assess my child as regards his/her special health care needs and to discuss these needs with my child’s physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.  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** |  | **Print Name** |  | **Date** | | | | | | |

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| **EMERGENCY MEDICATION (INHALER/EPINEPHRINE)—Florida Statute 1002.20**  *Florida law states a student may carry a metered dose inhaler or epinephrine auto-injector on his/her person and self-administer while in school with approval from his/her parents* ***and*** *physician.*  *The above named child may carry and self-administer his/her emergency medication.*   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Parent/Guardian signature:** | |  | Date: |  | | **Physician’s Signature: (required)** |  | | Date |  | |  |  | |  |  | |