|  |  |
| --- | --- |
| **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** |

 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 |  |
|  |  |  |  |

 |