



THE SCHOOL DISTRICT OF FLAGLER COUNTY
AUTHORIZATION FOR STUDENT TO CARRY AND SELF-ADMINISTER
Epinephrine Auto Injector (EPI-PEN) – Metered Dose Inhaler (MDI) – Insulin Pump –
All Diabetic Supplies (including Insulin, Syringes and Glucagon) – Pancreatic Enzymes
**** ONE DRUG PER FORM****

School Board Policy requires that:

1. Prescribed medication can only be administered or self-administered at school when failure to take such medication could jeopardize a student's health.
2. Students may carry or self-administer prescribed medication at school or away from school on official school business when:
 - a. This form is signed by a parent or guardian
 - b. The physician who prescribes the medication completes and signs the Physician's Authorization below.
3. Prescribed medications must **initially** be brought to school by the parent/guardian of the student for whom it was prescribed. It must be in the original container labeled by the pharmacy to include the following information:
 - a. **NAME OF STUDENT**
 - b. **NAME OF PHYSICIAN (Licensed and authorized by state law)**
 - c. **NAME OF MEDICATION**
 - d. **INSTRUCTIONS AS TO DOSAGE**

An additional supply of medication may be kept at the Nurse's Office.

PARENT'S STATEMENT

 Student's Name School Grade Date of Birth

I request that the above named student be authorized to carry and self-administer the prescribed Epi-Pen/MDI/Pump while in attendance at school. I will assume full responsibility for my child's self-administration of the issued medication and for any side effects and complications my child may have as a result of taking this medication (including, but not limited to, misuse or abuse) thereby releasing school personnel and the School Board from all liability.

 Parent/Guardian Signature Date Home Phone

 Address Business Phone Cell Phone

Physician's Authorization (TO BE COMPLETED BY PHYSICIAN)

The above student is under my medical supervision. I have ordered _____
 (Dosage Amount and Frequency)
 of _____
 (Name of Medication)

POSSIBLE REACTION OR SIDE EFFECTS: _____

REASON FOR MEDICATION TO BE SELF-ADMINISTERED AT SCHOOL: _____

I UNDERSTAND THAT THIS STUDENT WILL CARRY AND SELF-ADMINISTER THIS MEDICATION.

Date this order expires: _____

 Physician's Phone Number Physician's Signature Date

SCHOOL SHOULD RETAIN THIS FORM IN THE SCHOOL NURSE'S OFFICE 2019

School Use: Date Rec'd by Nurse/school health personnel : _____
 Date Administration and Teachers of Student Notified by Nurse /School health personnel : _____