Falls Lake Academy
Student Health Services

Medication Authorization
Valid for current school year only

Front(doctor) and back(parent) must be completed. Incomplete forms will NOT be accepted.

Student: _____ **DOB:** _____ **School Year:** **20___ - 20___**

I CERTIFY THAT ADMINISTRATION OF THE PRESCRIBED MEDICATION(S) TO THE STUDENT DURING THE SCHOOL DAY IS NECESSARY TO MAINTAIN AND SUPPORT THE STUDENT'S CONTINUED PRESENCE IN SCHOOL OR AT SCHOOL SPONSORED EVENTS.

Daily and PRN medications MAY NOT be self-administered or self-carried by students

Diagnosis	Medication	Dosage	Route	Time(s) to give
Daily medication for:				
PRN medication for:				

Physician Authorization for Student to Self-Administer Emergency Medication ☐ Yes ☐ No

Adult supervision is NOT needed. The student has been instructed in the treatment plan, self-administration for the listed medication(s), and has demonstrated the skill level necessary to self-administer the medication.

Allergic to:	☐ Diphenhydramine ☐ Other:	☐ 12.5 mg ☐ 25 mg ☐ Other:	By Mouth	☐ Upon Exposure ☐ Mild Reaction
Allergic to:	Epinephrine Auto Injector	☐ 0.15 mg ☐ 0.3 mg	Intramuscular	☐ Upon Exposure ☐ Severe reaction or more than 1 mild symptom ☐ If provided, repeat dose after 5 min. for continued symptoms
Seizures	☐ Diastat Gel ☐ Other:	☐ 5.0 mg ☐ 7.5 mg ☐ 10.0 mg ☐ Other:	☐ Rectal ☐ By Mouth ☐ Sublingual	☐ At onset of seizure ☐ Seizure > 5 min. ☐ Seizure > 10 min. ☐ Other:
Diabetes	Glucagon	☐ 0.5mg ☐ 1.0mg	Intramuscular	If student is unable to safely swallow or becomes unconscious
Asthma: *Exercise induced* ☐ ***Not Applicable***	☐ Albuterol ☐ Other:	☐ 2 puffs ☐ Other:	Inhaler w/spacer if provided	☐ Before very active exercise as needed to prevent symptoms ☐ Before PE as needed ☐ Before Recess as needed
Asthma: Yellow Zone	☐ Albuterol ☐ Other:	☐ 2 puffs ☐ 4 puffs ☐ 1 ampule	☐ Inhaler w/spacer if provided ☐ Nebulizer	☐ Every 4 hrs. as needed to relieve symptoms ☐ Other:
Asthma: Red Zone **Call 9-1-1 and Parent**	☐ Albuterol ☐ Other:	☐ 4 puffs ☐ 1 ampule	☐ Inhaler w/spacer if provided ☐ Nebulizer	For emergency symptoms ☐ May repeat every 20 min. x 3 doses

Physician/HCP Signature: _____Name *(printed)*: _____

Date: _____ Telephone: _____ Fax: _____

…continue on back…

Parent/Guardian

I understand that:

- Only emergency and diabetes care medications may be self-administered and/or self-carried
- Non-medical personnel sometimes conduct the medication administration if school nurse is unavailable.
- It is my responsibility to have an adult transport the medication to school.
- Medication must be provided in the original pharmacy labeled container with directions for administration. If medication is available over-the-counter, it must be provided in the original container/packaging, labeled with the student's name.
- Unused medications not picked up by the end of school year will be discarded.
- If medication is not available at the school, 9-1-1 will be called for emergencies.
- If my child participates in FLA before/after-school sponsored activities/sports, I will assume responsibility for contacting the advisor/coach of my child's medical condition. I will provide extra emergency medications that may be needed during the activity. I may contact the school nurse if assistance is needed in instructing the advisor in a medical procedure or if a copy of the information needs to be shared with them.

I request that:

- My child be administered the medication(s) as indicated in the healthcare provider's orders.
- If an emergency injection is ordered, I give permission for the school nurse to instruct designated staff in the administration technique.
- For students who self-carry and self-administer emergency medication as prescribed by the healthcare provider:
    - I give permission for my child to carry and administer the emergency medication listed on the reverse side during the school day, at school-sponsored activities, or while in transit to or from school. Adult supervision is not needed and I understand that:
        - I will provide back-up medications to be kept at the school (in addition to what my child will carry)
        - My child will be required to demonstrate the skill level necessary to self-administer the medication.
        - My child will be subject to disciplinary action if medication is used in any manner other than prescribed.

I authorize:

- The release and exchange of medical information between my child's healthcare provider, school nurse, and designated school personnel that is necessary in carrying out services for my child.

I hereby give permission for my child to receive medication during school hours. The medication has been prescribed by a licensed healthcare provider.

I hereby release the Falls Lake Academy, Inc. and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

Parent/Guardian Signature: _____ Print Name:_____

Phone: _____ Date:_____

Student (self-carry only): ☐ N/A

- I have demonstrated the proper use of my medication to the school nurse.
- I plan to keep my medication and equipment with me at school and school-sponsored activities.
- I will *only* use the medication as prescribed by my healthcare provider.
- My medication will be kept in the original container labeled with my name.
- I will *not* allow any other person to use my medication.
- I will notify a school staff member if I am having more difficulty than usual with my health condition.

Student signature: _____ Date: _____

I have observed the student and he/she demonstrates the ability and skill level necessary to use the emergency medication as prescribed by the healthcare provider. Inhaler ___ Epi Pen ___ Glucagon ___ Other ___

Nurse Signature: _____Date: _____

School nurse:

Date orders received and reviewed: _____ Nurse Signature: _____