AUTHORIZATION FOR PRESCRIBED MEDICATION FORM

Florida Christian School
4200 SW 89th Ave., Miami, FL 33165
305-226-8152 EXT 230

I hereby grant permission to the school nurse or his/her designee of Florida Christian School to assist in the administration of the following **prescribed medication** to my child while in school and away from school while participating in official school activities (field trips). I understand that I must bring the medication to the clinic in it's original container with a valid prescription. It is my responsibility to notify the school if and when these orders change. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinarily reasonable prudent person would under the same or similar circumstances.

Student Name: _____ Grade: _____

Parent's/Guardian's Name: _____ Contact: _____

Relationship: _____ Parent's/Guardian's Signatures: _____

Insert Copy of Prescription Below

The following section is to be completed by the Healthcare Practitioner (Physician, Advance Registered Nurse Practitioner, and/or Physician Assistant). A SEPARATE FORM MUST BE COMPLETED FOR EACH MEDICATION PRESCRIBED.

The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following medication, which is necessary to be given in school during the hours of 8 am – 3 pm when parent/guardian cannot be present to administer the medication. I am aware that trained non-medical staff may administer this Healthcare Practitioner Prescribed service.

PLEASE TYPE OR PRINT;
This order is to be effective for the school year: 20____ - 20____ or earlier stop date: _____

Parents should return all medical forms to the school nurse.

Diagnosis and Purpose for Medication: _____

_____

Allergies to Medications: _____

Name of Medication: _____ Strength (i.e. mg/tab):_____

Dose and Frequency:_____Time: _____ Duration:_____

Route: __ Oral __ Topical __ Subcutaneous __ I.M . __ Inhaled __ Other (describe) _____

Side Effects: _____

Healthcare Practitioner's Signature: _____ Date: _____
Healthcare Practitioner's Name (please print): _____
Office Address: _____ City: _____ State _____
Office number: _____

Date Medication stopped by Parent/Guardian: _____ Signature: _____

NURSING ORDERS – DIABETES TREATMENT

(To be completed by the Physician)

Parent/guardian will be responsible for providing all equipment, supplies, and medications.

Attach the Diabetes/Medication Treatment Plan or complete the information below.

Student has been trained by healthcare professional: ___ Yes ___ No

Blood glucose (BG) testing:

Target range for BG: _____ Type of Meter: _____

_____ Before lunch ____ Anytime student does not feel well

_____ Hours after meals ____ Other: _____

_____ Before/After exercise

Insulin Delivery: _____Syringe/Vial _____ Pen _____ Pump

Calculate insulin does for carbohydrate intake: Yes No

Carbohydrate Coverage: _____ #unit(s) of insulin per _____ grams of carbohydrate.

_____ Add carbohydrate does to correction dose at lunch.

INSULIN SLIDING SCALE	
Blood Sugar	**Dose**

Healthcare Practitioner's Signature: _____ Date: _____

Healthcare Practitioner's Name (please print): _____

FLORIDA CHRISTIAN SCHOOL

Authorization for Selected Over-the-Counter (OTC) Medications for the 2023-2024 School year.

Grades 5th – 12th

I hereby grant permission to the school nurse or his/her designee of Florida Christian School to administer of the following OTC medication(s) to my child while in school. These medications will be provided to the student at no additional cost to the family. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinarily reasonable prudent person would under the same or similar circumstances.

The Parent/Guardian will be notified *via email* following the administration of any oral medications.

Student's Name:	DOB:	Grade:
Known Allergies:		

Medication to be Administered by Mouth	**Approved Dosages** (All medications will be administered according to manufacturer's labels)	**Symptoms**	**Comments**
Acetaminophen (Tylenol) ☐ Yes ☐ No	☐ 1 tablet (500mg) ☐ 2 tablets (1000mg)	For relief of minor aches and pain.	Student with a temperature over 100.0 must be sent home
Ibuprofen (Advil, Motrin) ☐ Yes ☐ No	☐ 1 tablet (200mg) ☐ 2 tablets (400mg)	For relief of body aches & menstrual cramps.	
Excedrin ☐ Yes ☐ No	☐ 1 dose (2 tablets) ☐ ½ dose (1 tablet)	For relief of minor aches and pain. (Headache, muscle aches, menstrual cramps etc.)	
Midol ☐ Yes ☐ No	☐ 2 tablets	For relief of menstrual cramps	Alert: Aspirin sensitive students should be careful
Tylenol Cold and Sinus ☐ Yes ☐ No	☐ 1 dose (2 tablets) ☐ ½ dose (1 tablet)	For relief of sinus pressure, nasal congestion, and fever	
Advil Cold and Sinus ☐ Yes ☐ No	☐ 1 dose (2 tablets) ☐ 2 dose (1 tablet)	For relief of sinus pressure, nasal congestion and fever	
Zyrtec ☐ Yes ☐ No	☐ 5ml ☐ 10ml	For relief of the symptoms of seasonal allergies (sneezing, running nose, itching)	Alert: Avoid taking any other cold or allergy medicine unless your doctor has told you to
Loratadine (Claritin) ☐ Yes ☐ No	☐ 1 tablet (10mg)	For relief of the symptoms of seasonal allergies (sneezing, running nose, itching)	
Diphenhydramine HCl (Benadryl) ☐ Yes ☐ No	☐ 5ml ☐ 10ml	For relief of runny nose, itchy, watery eyes, sneezing, itchy throat, or nose	

Medication to be Administered by Mouth (con't)	**Approved Dosages** (All medications will be administered according to manufacturer's labels)	**Symptoms**	**Comments**
Pepto Bismol ☐ Yes ☐ No	☐ 1 dose (15ml) ☐ 2 doses (30ml)	For relief of stomachache, diarrhea, or heart burn	Alert: Do not take more than 6 doses within a 24-hour period
Calcium Carbonate (Tums) ☐ Yes ☐ No	☐ 3 chewable tablets	For stomachache or heartburn	Alert: may cause constipation
Mylanta ☐ Yes ☐ No	☐ 15ml ☐ 30ml	For relief of heartburn, acid indigestion, upset stomach, bloating	Alert: Do not take more than 6 doses within a 24-hour period

Comments:

Note: The Nurse will administer OTC medications not listed above as provided by the parent. Dosing will be administered to the student according to manufacture recommendations and/or doctors' orders. Any medication provided by a parent to the clinic will be labeled, locked and stored for the student. In the space below, please provide the name of the medication and the approved dosage. Medications must be brought in the original container.

Additional Medication Provided to the Clinic:

Name: _____Approved Dose: _____

Name: _____Approved Dose: _____

Name: _____Approved Dose: _____

Parent/Guardian Signature _____ Date: _____

FLORIDA CHRISTIAN SCHOOL

Authorization for Selected Over-the-Counter (OTC) Medications for the 2023-2024 School year.

Grades PreK – 4th

Student's Name:	DOB:	Grade:
Known Allergies:		

Medication to be Administered by Mouth	**Approved Dosages** (All medications will be administered according to manufacturer's labels)	**Symptoms**	**Comments**
Acetaminophen (Tylenol) ☐ Yes ☐ No	☐ 5ml (24-35lbs) ☐ 7.5ml (36-47lbs) ☐ 10ml (48-59lbs) ☐ 12.5ml (60-71lbs) ☐ 15ml (72-95lbs)	For relief of minor aches and pain.	Student with a temperature over 100.0 must be sent home
Ibuprofen (Advil, Motrin) ☐ Yes ☐ No	☐ 5ml (24-35lbs) ☐ 7.5ml (36-47lbs) ☐ 10ml (48-59lbs) ☐ 12.5ml (60-71lbs) ☐ 15ml (72-95lbs)	For relief of body aches & menstrual cramps.	
Zyrtec ☐ Yes ☐ No	☐ 5ml ☐ 10ml	For relief of the symptoms of seasonal allergies (sneezing, running nose, itching)	Alert: Avoid taking any other cold or allergy medicine unless your doctor has told you to
Diphenhydramine HCl (Benadryl) ☐ Yes ☐ No	☐ 5ml ☐ 10ml	For relief of runny nose, itchy, watery eyes, sneezing, itchy throat, or nose	
Pepto Bismol ☐ Yes ☐ No	☐ 1 dose (15ml) ☐ 2 doses (30ml)	For relief of stomachache, diarrhea, or heart burn	Alert: Do not take more than 6 doses within a 24-hour period
Calcium Carbonate (Tums) ☐ Yes ☐ No	☐ 3 chewable tablets	For stomachache or heartburn	Alert: may cause constipation
Mylanta ☐ Yes ☐ No	☐ 15ml ☐ 30ml	For relief of heartburn, acid indigestion, upset stomach, bloating	Alert: Do not take more than 6 doses within a 24-hour period

Comments:

Note: The Nurse will administer OTC medications not listed above as provided by the parent. Dosing will be administered to the student according to manufacture recommendations and/or doctors' orders. Any medication provided by a parent to the clinic will be labeled, locked and stored for the student. In the space below, please provide the name of the medication and the approved dosage. Medications must be brought in the original container.

Additional Medication Provided to the Clinic:

Name: _____Approved Dose: _____

Name: _____Approved Dose: _____

Name: _____Approved Dose: _____

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The Parent/Guardian will be notified *via email* following the administration of any oral medications.

Parent/Guardian Signature _____ Date: _____