MEDICATION AUTHORIZATION
Orange County Schools

HEALTH CARE PROVIDER: COMPLETE ALL ITEMS IN BOLD

Student's Name: _____ **Date of Birth:** ___/___/___

School: _____ Telephone: _____ FAX: _____

Medication: _____ **Dosage**: _____ **Route:** _____ **Frequency:** _____

Time(s) medication is to be given: _____ **Dates to be given from:** ___/___/___ **to** ___/___/___
(Medication authorization will be in effect for one calendar year unless otherwise specified.)

Purpose of medication: _____

Side Effects/Contraindications: _____

Some medications may be self-administered at school and/or on a field trip. If appropriate, I consider this student to have the maturity and knowledge to self-administer his/her medication. ____**Yes**___**No**

Health Care Provider's Signature: _____ **Date:** ___/___/___

Health Care Provider's Name/Title (print): _____ **Telephone:** _____

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication in accordance with OCS policy 6125, *Administering Medicines to Students*. All medications, including over-the-counter products, have been prescribed by a licensed health care provider. Medications will be furnished in current pharmacy-labeled bottles with identifying information and brought to school by parent/guardian. I assume full responsibility for informing the school of any change in my child's health and/or medication. I agree that medication dosage cannot be changed without a physician's order. Further, I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication.

NOTE: I understand some emergency medications may be self-carried and administered. Additionally, scheduled medication may be self-administered under supervision while traveling on a field trip. If appropriate, I consider my student to have the maturity and knowledge to self-administer his/her medication and understand that the school system can assume no liability for monitoring the self-administration. I assume the responsibility for ensuring that my child is carrying and taking their medication as ordered. Prior to acceptance of a self-administered medication on campus, the school nurse must ascertain the student's maturity and knowledge, as well as review/ensure compliance with OCS protocol. Schools may revoke this privilege if the student proves to be irresponsible or incapable. With these facts in mind, **I give permission for my child to self-administer medication**: _____**Yes** _____**No**

Parent/Guardian Signature: _____ **Telephone**: _____ **Date**: ___/___/___

----------(SCHOOL USE ONLY)----------

Reviewed/Received by: _____ (School Nurse's Signature) _____ (Date)

MEDICATION CHECK-IN & SIGN-OUT LOG

Date	Medication	Amt. Rec'd	Received by (signature)	Received from (signature)

Drug Disposal Method: ___ Remainder of Medication Retrieved Date:_____ Initials:_____
___ NA - No drug supply remained Date:_____ Initials:_____
___ Disposed per OCS procedure Date:_____ Initials:_____

MEDICATION AUTHORIZATION
Orange County Schools

MEDICATION AUTHORIZATION FOR SELF-ADMINISTRATION

Protocol:

1. The health care provider, parent and student must complete and sign the Medication Authorization form on an annual basis.

2. The school nurse, in consultation with the principal, is the final judge of the student's compliance with these guidelines in the school.

3. Self-administration of medication shall comply with OCS Policy 6125 and accompanying procedure.

4. The student must demonstrate sufficient maturity and knowledge to use the mediation safely and correctly.

Student Section:

My health care provider, parent/legal guardian, and I agree that I have sufficient maturity and knowledge to use the medication (named on this form) safely and correctly. I agree to:

- have my medication readily available with the help of my parent/legal guardian
- keep the medication in my possession at all times and not leave it in a place accessible to other students, nor allow or offer any use to other students
- use medication in a responsible manner, in accordance with my health care provider's orders
- notify the school office or school nurse if I am having more difficulty than usual with my health condition

Student Signature:_____Date: ___/___/___

Review with Student:

_____Demonstrates correct use/administration of medication

_____Recognizes need for and proper timing for medication as prescribed by health care provider

_____Identifies a proper location and method to carry medication

_____Knows health condition well

_____Keeps a second labeled container in med cart or nurse's office (as indicated)

_____Review Emergency Action Plan (as indicated)

Final Consent to Allow Self-Administration of this Medication:

_____Self-administration is not an option for this student or this medication

_____Self-administration under supervision may occur on field trips

_____Self-administration is appropriate for this student and this medication

School Nurse Signature:_____Date: ___/___/___