

THE SCHOOL DISTRICT OF VOLUSIA COUNTY
HEALTH SERVICES
**AUTHORIZATION TO ADMINISTER PRESCRIPTION/ NON-PRESCRIPTION MEDICATION
(TO STUDENTS BY SCHOOL PERSONNEL)**

NOTE: SCHOOL BOARD POLICY REQUIRES THAT:

1. Prescription medication can only be administered at school when failure to take such medication could jeopardize a student's health.
2. Medication must be brought to school by the parent/guardian or their adult designee. It must be in the original container labeled by the pharmacy to include the following, and must exactly match the doctor's orders:

- A. NAME OF STUDENT**
- B. NAME OF DOCTOR (Licensed and authorized by Florida law to order prescription medication)**
- C. NAME OF MEDICINE**
- D. INSTRUCTION AS TO DOSAGE (amount and time, such as 12:00 PM, noon, or lunchtime)**
- E. INDICATION OF SPECIAL STORAGE, IF NEEDED (refrigeration, etc.)**

*** PLEASE COMPLETE ALL AREAS ***			
DOCTOR'S AUTHORIZATION (To be completed by doctor) <u>ONLY ONE PRESCRIPTION DRUG PER FORM</u>			
Student's Name _____		School _____	Grade _____
The above student is under my medical supervision. I have ordered _____ (All PRN medication orders must note frequency) (Name of Medication)			
DOSAGE		EXACT TIME	
_____ at _____		_____ at _____	
Reason for medication to be administered at school: _____			
Possible reactions or side effects: _____			
This authorization is valid for this school year only unless earlier date is specified: _____			
Doctor's Stamp _____	Doctor's Signature _____	Phone _____	Date _____
Address _____		City _____	State _____
			Zip _____

<u>PARENT/GUARDIAN PERMISSION</u>	
I hereby request that my child be given the above medication while in school and away from school for school activities. 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 should have acted under the same or similar circumstances.	
<input type="checkbox"/> Yes <input type="checkbox"/> No I give permission for the physician and school district personnel to exchange pertinent information pertaining to this child's condition/progress.	
Signature of Parent/Guardian: _____	
Parent/Guardian's Name (Printed) _____	Address _____

Nursing Supervisors Signature Date

SCHOOL SHOULD RETAIN THIS FORM IN THE HEALTH CLINIC