

AUTHORIZATION TO CARRY AND SELF ADMINISTER

MUST BE COMPLETED AND SIGNED BY A PARENT/GUARDIAN AND PHYSICIAN ONLY IF YOUR CHILD IS AT AN APPROPRIATE AGE TO

SELF CARRY/SELF ADMINISTER (OTHERWISE, THIS FORM IS NOT REQUIRED)

STUDENT NAME: _____ DATE OF BIRTH: _____

GRADE: _____ HOMEROOM: _____

PARENT/GUARDIAN: _____ PARENT/GUARDIAN PHONE: _____

I. PARENT/GUARDIAN PERMISSION:

I hereby request and give permission for my child to be allowed to carry and/or self-administer the medication marked below by physician initials per Florida Statute while in school and away from school for school-related activities. Administration will be in compliance with written directions from my child's physician per the written prescription. I will notify the school immediately if the health status of my child changes, we change physicians, we change home, work, or emergency telephone numbers, or there is a change or cancellation of the order. I understand it is my responsibility to ensure that my child has the proper medication, that it is within the expiration date for his/her use, and that the delivery system is functioning properly. I understand that no other medications other than those listed below are allowed to be carried by my student. I acknowledge that the school nurse is authorized to provide training to any school personnel as required, and that the school nurse has the authority to revoke the self-administration privilege for any student the nurse may assess as unsafe or ineffective in his/her professional judgment. If my student can self-administer, it is strongly encouraged that a back-up supply of medication is provided to the school clinic. I understand that if my student cannot self-administer their own medication, I must provide a back-up supply for the school clinic. I hereby agree to indemnify and hold Maclay School and their officers, employees, contractors, and agents harmless from any and all lawsuits, claims, demands, expenses, and actions against them rising from harm to any persons caused by my child's actions with regards to self-carried medication.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

II. PHYSICIAN STATEMENT:

The above named student may carry and/or self-administer the following medication as outlined below (please mark all boxes that are applicable and initial to the right of all marked boxes):

Metered Dose Inhaler (MDI) ☐ Student may carry ☐ Student may self-administer Initials: _____

Epinephrine (autoinjector) ☐ Student may carry ☐ Student may self-administer Initials: _____

NOTE: If Epinephrine is used, 9-1-1 MUST be activated!

Pancreatic Enzyme Supplement ☐ Student may carry ☐ Student may self-administer Initials: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

PHYSICIAN NAME (please print): _____ TELEPHONE: _____

III. REGISTERED NURSE STATEMENT:

I acknowledge that the student named above is authorized to carry and/or self-administer the indicated medication above, and it is my professional judgement that this student can safely and effectively carry and/or self-administer this medication.

REGISTERED NURSE SIGNATURE: _____ DATE: _____

REGISTERED NURSE NAME (please print): _____

A NEW AUTHORIZATION IS REQUIRED EACH SCHOOL YEAR