

THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
HEALTH SERVICES
J.E. Hall Center, 30 E. Texar Dr.
Pensacola, FL 32503
Phone: 469-5456

AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

THIS FORM IS VOID IF ALTERED IN ANY WAY

INSTRUCTIONS: Each of the three sections must be completed by the appropriate person as follows: Parts I and III by Parent/Guardian. Part II by Physician. Please return the completed form to the school health room/office.

I. STUDENT INFORMATION (To be Completed by Parent/Guardian).

Student's Name (Last, First, Middle)	Birth Date	Medicaid #	Grade/Homeroom Teacher
Parent/Guardian	Address		
Home Phone	Work Phone	Other Phone (Cellular, Beeper, etc.)	

II. ACTION PLAN (To be Completed by Physician). Please complete all spaces.

THIS REQUEST IS TO BE EFFECTIVE FOR THE SCHOOL YEAR 20____ - 20____ OR EARLIER STOP DATE: _____

MEDICATION: _____

GENERIC NAME (IF USED): _____

DOSAGE AMOUNT: _____ TIME TO BE ADMINISTERED AT SCHOOL: _____

CONDITION FOR WHICH DRUG IS TO BE GIVEN: _____

NOTE ANY UNTOWARD SIDE EFFECTS: _____

INHALANT PRESCRIPTIONS:

This student is both capable and responsible for self-administering this medication:

☐ No ☐ Yes – Supervised ☐ Yes – Unsupervised

This student may carry this medication: ☐ No ☐ Yes

Print Physician's Name	Physician's Address:	Phone
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Physician's Signature: _____

III. PARENTAL PERMISSION (To be Completed by Parent/Guardian). Form is void if this section is incomplete.

I request the designated school personnel or its agents to assist my child in the administration of the above prescribed medication. I give permission for my child to take this medication while in school or while participating in school activities away from the school site. I understand that: (1) there is no liability on the part of the school district, its personnel, or agents, including Escambia County Health Department personnel, for civil damages as a result of the administration of this medication by my child when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances; (2) this medication must be brought to the school only by a responsible adult; (3) this medication must be in its original labeled container; (4) this medication will be destroyed if it is not picked up within one week following the above stop date or one week after the close of the current school year, whichever occurs first. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and school health personnel of the Escambia County Health Department and the School District of Escambia County.

Parent/Guardian Signature: _____ Date: _____

Medication orders must be renewed by the attending physician and release signed by the parent/guardian annually. Each medication, or any change in medication requires a new form. The parent/guardian will be responsible for ensuring that medicines provided for the school have not expired.

Pursuant to Section 232.46, Florida Statute, any student who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated personnel.