VOLUSIA COUNTY SCHOOLS

VOLUSIA STUDENT SERVICES
Student Health Services

Authorization for Student to Self-Carry / Self-Administer Epinephrine Auto-Injector

NOTE	SCHOOL BOARD POLICY REQUIRES THAT:

1. Prescribed medication can only be self-carried at school when failure to take such medication could jeopardize a student's health.
2. Students may carry an epinephrine auto-injector for self-injection/school personnel administration, if:
   a) This form is signed by a parent or guardian.
   b) The provider who prescribed the medication competes and signs the Provider's Authorization below
   c) Physician determines if student can self-administer medication (In the event the student is unable to self-administer, school personnel will perform medication administration.)
3. 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 provider's orders:
   a) **Name of student**
   b) **Name of provider's (licensed and authorized by Florida Law to order prescription medication)**
   c) **Name of medicine**
   d) **Instructions as to dosage**

***** PLEASE COMPLETE ALL AREAS *****
PROVIDER'S AUTHORIZATION (To be completed by provider) **ONLY ONE DRUG PER FORM**

Student's Name _____ School _____ Grade _____

The above student is under my medical supervision. I have ordered _____
(Name of Medication)

DOSAGE		EXACT TIME
_____	at	_____
_____	at	_____

Reason for medication to be administered at school: _____

Possible reactions or side effects:

Self-Administer: ☐ Yes ☐ No

Date this prescription expires: _____

Provider's Stamp _____ Provider's Signature _____ Phone _____ Date _____

Address _____ City _____ State _____ Zip Code _____

Parent/Guardian Statement **Student Can Self - Administer** ☐ YES ☐ NO

I request that the above-named student be authorized to self-administer the following prescription medication while in attendance at school and school activities. I will assume full responsibility for my child's self-administration and for any side effects and complications my child may have as a result of taking this medication. In addition, I assume full responsibility for any ramification that results from my child's possession of this medication. I understand that it is my obligation to ensure that the medication is not kept beyond its effective date. I agree to indemnify and hold the health department and school board, its employees and assets harmless from any and all liability or damage that may occur due to my child's possession, handling, administration, or lack of safekeeping of said medication. I agree, in the event, if my child is deemed unable to administer medication by a physician or in event of an emergency student is not able to self- administer medication school personnel will administer medication.

Signature of Parent/Guardian: _____ Parent/Guardian Name (Printed): _____

Address _____ Home Phone Number _____ Mobile No. _____ Date _____

RN Supervisor Signature: _____ Date: _____

SCHOOL SHOULD RETAIN THIS FORM IN THE HEALTH CLINIC