VOLUSIA COUNTY SCHOOLS

VOLUSIA STUDENT SERVICES
Student 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 Provider (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 *****
PROVIDER'S AUTHORIZATION (To be completed by provider) **ONLY ONE PRESCRIPTION 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: _____

This authorization is valid for this school year only unless earlier date is specified: _____

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

Address _____ City _____ State _____ Zip Code _____

Parent / Guardian's Statement

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.

☐ Yes ☐ 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 _____ Home Phone Number _____ Emergency Phone No. _____ Business Phone _____

RN Supervisor Signature: _____ Date: _____

SCHOOL SHOULD RETAIN THIS FORM IN THE HEALTH CLINIC

200 North Clara Avenue | Deland, FL 32720 | (386) 734 -7190