VOLUSIA COUNTY SCHOOLS

VOLUSIA STUDENT SERVICES
Student Health Services

Student Self-Administration Authorization

NOTE	SCHOOL BOARD POLICY REQUIRES THAT:

1. Prescribed medicine can only be administered or self-administered at school when failure to take such medication could jeopardize a student's health.

2. Students may self-administer prescribed medication at school or away from school on official school business when:
   a) This form is signed by a parent or guardian.
   b) The provider who prescribed the medicine completes and signs the Provider's Authorization below.

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 (licensed and authorized by Florida Law to order prescription medication)
   c) Name of medicine
   d) Instruction as to dosage

Parent / Guardian's Statement

Student's Name: _____ School: _____ Grade:_____

I request that the above-named student be authorized to self-administer the following prescription medication while in attendance at school. I will assume full responsibility for my child's self-administration of such medication and for any side effects and complications my child may have as a result of taking this medication, thereby releasing school personnel and the School Board from all liability.

☐ **Yes** ☐ **No** **I give permission for the provider and school district personnel to exchange pertinent information pertaining to this child's medication/condition/progress.**

Parent/Guardian Signature _____ Date _____

Address _____ Home Phone _____ Business Phone _____

***** PLEASE COMPLETE ALL AREAS *****
PROVIDER'S AUTHORIZATION (TO BE COMPLETED BY PROVIDER) ONLY ONE DRUG PER FORM

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

Possible Reactions or Side Effects: _____
Reason for Medication to be administered at school:

I UNDERSTAND THAT THIS STUDENT WILL SELF-ADMINISTER THE MEDICATION.

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

Provider's Stamp _____ Provider's Signature _____ Phone No. _____ Date _____

RN Supervisor Signature: _____ Date: _____

SCHOOL SHOULD RETAIN THIS FORM IN THE HEALTH CLINIC