Suwannee County Schools
AUTHORIZATION FOR MEDICATION ADMINISTRATION

- **Only medications authorized by a physician may be administered by school health personnel, the principal, or his/her designee. The physician must complete & sign this form. The parent must also sign the form.**
- **Prescription medications must be supplied in the original container.** Ask the pharmacist to divide the medication into two bottles; one for school/one for home. **Over the counter medications must be supplied in the original, *unopened* container.**
  - It is the parent's responsibility to: notify the school when there is a change in medication, provide the school with a new completed authorization for medication form and provide all necessary medication, supplies, and equipment. **No medications will be accepted without all necessary forms completed and equipment/ supplies provided to the school.**
  - By signing this medical authorization the parent grants school health personnel, the principal, or his / her designee permission to:
    - ✓ assist in or perform the administration of each medication or treatment / procedure to or for their child during the school day including when he/she is away from school property for official school events
    - ✓ share relevant information pertaining to this form with appropriate staff
    - ✓ contact their child's healthcare provider when necessary
    - ✓ have a photograph taken of their child and placed in his/her medication file for identification purposes only

STUDENT NAME _____ DATE OF BIRTH _____GRADE_____

TEACHER_____ SCHOOL: BES BHS SES SHS SIS SMS SPS

ALLERGIES _____

DIAGNOSIS _____

BEGINNING DATE_____ENDING DATE_____

MEDICATION NAME and STRENGTH _____

DOSE_____ Route_____ Time_____

FREQUENCY (i.e.: once daily; every six hours; every 15 minutes until symptoms subside) _____

_____

SIGNIFICANT SIDE EFFECTS_____

SPECIAL INSTRUCTIONS/EMERGENCY PRECAUTIONS (if any) _____

LIST ANY PROCEDURES THE STUDENT HAS BEEN TRAINED TO PERFORM**, INCLUDING THE DATE OF TRAINING**

COMPLETION _____

_____

Physician's Name **(Printed or Stamped)** **Physician's Signature** **DATE** Physician **SIGNED**

_____

Physician's Phone and FAX Number **Physician's Address**

The undersigned parent/guardian agrees to indemnify and hold the School Board of Suwannee County, Florida, and its employees (District) harmless with respect to any claim, liability or damages that may arise as a result of any action the District may take in reliance upon or in any manner in connection with the Medical Authorization they have granted. Pursuant to Statute 1006.062(2), *there shall be no liability for civil damages as a result of the administration of such medication, when the person administering such medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances.*

_____

Parent/Guardian Name **(PRINTED)** Parent /Guardian **SIGNATURE** **DATE** Parent/Guardian **SIGNED**

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Telephone Numbers where Parents/Guardians can be reached. Please include work number with ext, if any and cell phone number.