Suwannee County Schools

AUTHORIZATION FOR MEDICATION ADMINISTRATION

- Only medications authorized by a Florida licensed prescriber may be administered by school health personnel, the principal, or his/her designee.
- The Florida licensed prescriber must complete & sign this form. The parent must also sign the form.
- Prescription medications must be supplied in the *original* container. If the same medication is given at home, parents will need to 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 and provide the school with a new completed *Authorization for Medication Administration* form; prescription; 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/for their child while in school, participating in school sponsored activities, or in transit to or from school or school sponsored activities
  - ✓ 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 CES SHS SIS SMS SPS

DIAGNOSIS (for which medication is prescribed) _____ALLERGIES _____

Reason for Giving During School Day_____ BEGINNING DATE_____ENDING DATE_____

MEDICATION NAME and STRENGTH _____

DOSE _____ ROUTE _____ TIME _____

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

SIGNIFICANT SIDE EFFECTS OF MEDICATION _____

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 232.46(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

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