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_____
ALLERGIES _____
DIAGNOSIS _____ Reason for Giving During School Day_____
PURPOSE OF MEDICATION _____
BEGINNING DATE_____ENDING DATE_____
MEDICATION NAME and STRENGTH _____
DOSEAGE AND ROUTE (i.e.: one 10 mg tablet; 2 ml) _____
FREQUENCY (i.e.: once daily; every six hours; every 15 minutes until symptoms subside) _____
_____
SPECIFIC TIMES and/or CONDITIONS UNDER WHICH MEDICATION SHOULD BE ADMINISTERED (i.e.: at 11 am everyday; every six hours as needed for shortness of breath; when signs of allergic reaction occur) _____
_____
SPECIAL INSTRUCTIONS (i.e. description of seizure activity for which the medication will be administered, description of s/s of allergic reaction for which the medication will be administered)_____
_____
SIDE EFFECTS _____
LIST ANY PROCEDURES THE STUDENT HAS BEEN TRAINED TO PERFORM, INCLUDING THE DATE OF TRAINING COMPLETION _____
_____
LIST ANY LIMITATIONS/PRECAUTIONARY MEASURES THAT SHOULD BE CONSIDERED; e.g. physical education, outdoor activities, transporting, lifting, moving, special devices/equipment_____
_____
LIST ANY EMERGENCY PRECAUTIONS/HEALTH EMERGENCIES THAT SHOULD BE ANTICIPATED FOR THIS STUDENT; e.g. allergy triggers, diabetic reactions, etc.:_____

_____

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.