

SCHOOL DISTRICT OF DESOTO COUNTY	AUTHORIZATION FOR ADMINISTRATION OF <u>PRESCRIPTION MEDICATION</u>
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THIS FORM IS VOID IF ALTERED IN ANY WAY

INSTRUCTIONS: The appropriate person must complete each of the three sections as follows: Parts I and III by Parent/Guardian, Part II by Physician. Please return the completed form to the School Nurse.

1. STUDENT INFORMATION (To Be Completed By Parent/Guardian)			
Student's Name (Last, First, Middle)	Birth Date	Medicaid #	Grade/Homeroom Teacher
Parent/Guardian		Address	
Home Phone	Work Phone	Other Phone (Cell, Beeper, etc.)	

II. ACTION PLAN (To be completed by Physician). Please complete all spaces.

THIS REQUEST IS TO BE EFFECTIVE THE SCHOOL YEAR 20__ - 20__ OR EARLIER STOP DATE _____		
MEDICATION: _____		
GENERIC NAME (IF USED): _____		
DOSAGE AMOUNT: _____ TIME TO BE ADMINISTERED AT SCHOOL _____		
CONDITION FOR WHICH MEDICATION IS TO BE GIVEN _____		
NOTE ANY UNTOWARD SIDE EFFECTS: _____		
INHALANT or EPI-PEN PRESCRIPTIONS:		
This student is both capable and responsible for self-administering this medication: ___No ___Yes – Supervised ___Yes – Unsupervised		
This student may carry this medication: ___No ___Yes		
Print Physician's Name	Physician's Address	Phone
Physician's Signature:		Date:

III. PARENTAL PERMISSION (To be completed by Parent/Guardian). Form is void if this section is incomplete.

I request the School Nurse or designated school personnel to assist my child in the administration of the above prescribed medication. I give permission for my child to take this medication while in school or while participating in school activities away from the school site. I understand that: (1) there is no liability on the part of DeSoto County School District, its personnel or DeSoto County Health Department personnel, for civil damages as a result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances; (2) this medication must be brought to the school only by a responsible adult; (3) this medication must be in its original labeled container; (4) this medication will be destroyed if it is not picked up within one week following the above stop date or one week after the close of the current school year, whichever occurs first. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and school health personnel of the DeSoto County Health Department and the School District of DeSoto County.

Parent/Guardian Signature: _____ **Date:** _____

Medication orders must be renewed by the attending physician and release signed by the parent/guardian annually. Each medication, or any change in medication, requires a new form. The parent/guardian will be responsible for ensuring that medicines provided for the school have not expired.

Pursuant to Section 232.46 Florida Statute, any student who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated personnel.