

THE SCHOOL DISTRICT OF ESCAMBIA COUNTY  
HEALTH SERVICES  
J. E. Hall Center 30 E. Texar Dr.  
Pensacola, FL 32503  
Phone: (850) 469-5456

**AUTHORIZATION FOR  
ADMINISTRATION OF  
NON-PRESCRIPTION MEDICATION**

(Acetaminophen, Calcium Carbonate, or Ibuprofen)

**THIS FORM IS VOID IF ALTERED IN ANY WAY**

**INSTRUCTIONS:** Each of the three sections must be completed by parent/guardian. Please return the completed form to the school clinic.

**I. 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 (Cellular, Beeper, etc.)		

**II. ACTION PLAN (To Be Completed By Parent/Guardian). Please complete all spaces.**

THIS REQUEST IS TO BE EFFECTIVE FOR THE SCHOOL YEAR 20\_\_\_\_-20\_\_\_\_ OR EARLIER STOP DATE: \_\_\_\_\_

Circle **only one** medication from the approved list below. Write the brand name in the blank. All other over-the-counter medications require an Authorization for Administration of Prescription Medication from the students's medical provider.

Acetaminophen \_\_\_\_\_

Calcium Carbonate \_\_\_\_\_

Ibuprofen \_\_\_\_\_

Dosage Amount: \_\_\_\_\_ (Medication dosage and time schedule must be age appropriate within recommendations on manufacturer's label.)

For Condition/Symptom: \_\_\_\_\_  
\_\_\_\_\_

**III. PARENTAL PERMISSION (To Be Completed By Parent/Guardian). Form is void if this section is incomplete.**

I request the designated school personnel to assist my child in the administration of the above described 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 the school district, its personnel, or agents, including Escambia 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 reasonable 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 Escambia County Health Department and the Escambia School District.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Non-prescription medication requests must be renewed by the parent/guardian 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.

# MEDICATION PROTOCOL AT SCHOOL

## PARENT RESPONSIBILITIES

### Prescription Medication

1. An Authorization for Administration of Prescription Medication form must be filled out by the physician, and signed by the parent.
2. A separate authorization form must be filled out for **EACH** medication administered.
3. Changes in medication require a **new** authorization form signed by the physician and parent.
4. Medication must be in the original pharmacy-labeled container.
5. No more than a 30-day supply of medication may be accepted.
6. A responsible adult must deliver and pick-up the medications in the school clinic.
7. Communicate any medication changes directly to clinic staff, including discontinued medications.
8. If your child is authorized to receive an early morning medication at school, do not give this dose at home.
9. When medication is discontinued or school year ends, pick-up all unused medication within one week. Unclaimed medications will be destroyed.

### Non-Prescription Medication

1. An Authorization for Administration of Non-Prescription Medication form must be filled out by the parent for students to receive acetaminophen, calcium carbonate, or ibuprofen. All other over-the-counter medications require an Authorization for Administration of Prescription Medication.
2. A **separate** authorization form must be filled out for **EACH** medication administered.
3. Non-prescription medication must be in the original bottle (**small or travel size**) with the manufacturer's label.
4. A responsible adult must deliver and pick-up the medications in the school clinic.
5. Communicate any medication changes directly to clinic staff, including discontinued medications.
6. Medication dosage must be age appropriate as stated on the manufacturer's label.
7. When medication is discontinued or school year ends, pick-up all unused medication within one week. Unclaimed medications will be destroyed.