THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
Health Services
J. E. Hall Center 30 E. Texar Dr.
Pensacola, FL 32503
Phone: 469-5456

AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

THIS FORM IS VOID IF ALTERED IN ANY WAY

INSTRUCTIONS: Each of the three sections must be completed by the appropriate person as follows: Parts I and III by Parent/Guardian, Part II by Physician. Please return the completed form to the school health room/office.

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 Physician). Please complete all spaces.

THIS REQUEST IS TO BE EFFECTIVE FOR 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 DRUG IS TO BE GIVEN: ____________

NOTE ANY UNTOWARD SIDE EFFECTS: ____________

FOR INHALANT PRESCRIPTION OR EPINEPHRINE AUTO-INJECTOR PRESCRIPTION ONLY:
(Circle One)

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 designated school personnel or its agents 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 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 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 Escambia County Health Department and the School District of Escambia County. Furthermore, if my child is covered by Medicaid and receives health services under an IEP, I consent for the school district to bill Medicaid for those services. I assume all risk and liability with respect to my child's use of epinephrine, including any related injection device.

Parent/Guardian Signature: ____________ Date:____________

Pursuant to Section 1006.062, 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.

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.