THE SCHOOL BOARD OF SARASOTA COUNTY, FLORIDA and
FLORIDA DEPARTMENT OF HEALTH IN SARASOTA COUNTY
SCHOOL HEALTH SERVICES
1960 LANDINGS BOULEVARD, SARASOTA, FL 34231 PHONE (941) 927-9000

# MEDICATION/TREATMENT AUTHORIZATION

**Instructions:** Read instructions on page two prior to completing the form.

Student Name _____ Sex _____ DOB _____ Grade _____

School _____ Student No. _____ Fax No. _____

**The following section is to be completed by the parent or legal guardian.**

I hereby grant permission to the principal or his/her designee of _____ School to assist in the administration of the prescribed medication and/or treatment to my child while in school and away from school while participating in official school activities (F.S.1006.062). **It is my responsibility to notify the school if and when these orders change**. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication and/or treatment where the person administering such medication and/or treatment acts as an ordinarily reasonably prudent person would under the same or similar circumstances.

Parent/Guardian Name _____ Relationship _____

Emergency Phone _____ Home Phone _____ Work Phone _____

Address _____

List student allergies _____

Parent/Guardian Signature _____ Date _____

**The following section is to be completed by the prescribing physician.**
**A separate form must be completed for each medication or treatment prescribed.**
The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following medication/treatment, which is necessary to be given in school. I am aware that trained non-medical staff may administer this physician prescribed service.
**This order is to be effective for the school year: 20____ - 20____ or earlier stop date _____.**

| |
|---|
| Diagnosis (for this medication/treatment) |
| Treatment |
| Name of Medication Brand Generic Strength (i.e. mg/tab) |
| Instructions to give Amount (i.e. No. of tablets or teaspoons) _____ Time(s) _____<br>Frequency (i.e: every 6 hrs PRN) Duration (i.e: 10 days) |
| Route ☐ Oral ☐ Topical ☐ Subcutaneous ☐ I.M. ☐ Inhaled ☐ Other (describe) |
| Time medication is given at home (if applicable) |
| Possible side effects |
| Medication expiration date to follow manufacturer's expiration date? ☐ Yes ☐ No |
| Is student authorized to carry and use asthma inhalation medication or Epinephrine Auto-Injector? ☐ Yes ☐ No |
| Has student been instructed in the use of asthma inhaler or Epinephrine Auto-Injector? ☐ Yes ☐ No |
| Is student authorized to carry and self-administer pancreatic enzymes? ☐ Yes ☐ No |
| Has student been instructed in the use of pancreatic enzymes? ☐ Yes ☐ No |
| Other Information |
| Physician Name _____ |
| Office Address _____ Phone _____ Fax _____ |
| Physician Signature _____ Date _____ |
| Medication order reviewed by school RN/LPN _____ Date _____ |
| Medication stopped by Parent/Guardian Signature _____ Date _____ |

## MEDICATION/TREATMENT AUTHORIZATION

**Instructions:** For medical/treatment administration during school hours, read the below requirements.

If your child needs to have medication(s)/treatment(s) given during the school day, state regulations and school board policy require that you and your doctor provide written permission for administration of both prescribed and over-the-counter medication(s) or treatment(s).

**Medication refers only to those products which have been approved by the "Food and Drug Administration" (FDA) for use as a drug.**

- **Prescribed medications** must arrive in a container with the original, unaltered prescription label attached. **The label must display all legal information required for a pharmacist to dispense a prescription medication such as valid issue and expiration dates, the patient's name, the medication name and dosage instructions, and the doctor's name. The label information must match the physician's order.**

- **Over-the-counter medications** must arrive in the original, unopened store-issued container. Take the time to label the container with your child's full name and birth date, the date you brought the medication to school and the **dosage prescribed by the doctor.**

- The Medication/Treatment Authorization Form on the reverse side of this document must be completed entirely and accompany any medication (either prescribed or over-the-counter) to be given to your child in school. **Both a parent/legal guardian and the prescribing doctor must sign the form.** Staff will not be able to administer medications to your child without this **written consent**.

- The parent, legal guardian, or an authorized adult must hand carry medications to the school health room. The medication brought into the school health room must match the prescribed medication amount. For example, if the prescribed amount is ½ tablet, then it is the responsibility of the pharmacy/parent to cut the tablets. The health room aide upon receipt will verify the quantity of each medication. **Albuterol and Epinephrine Auto-Injectors must be delivered in the original box with the pharmacy label. Do not send medications to school with your child.**

- **The RN/LPN at your child's school may need to call the doctor's office for medication/treatment clarification.**

The parent or legal guardian will need to pick up the medication at the end of the school year or if the medication is discontinued or changed during the school year. **If the medication is not picked up, it will be discarded.**