ST. JOHNS COUNTY SCHOOL DISTRICT

HEALTH SERVICES

AUTHORIZATION TO ASSIST IN THE ADMINISTRATION OF MEDICATION/TREATMENT

Student Name: _____ Date of Birth: _____
School: _____ Teacher/Grade: _____

NURSING SERVICES AND MEDICATION/TREATMENT ORDER

ALL INFORMATION MUST MATCH THE PRESCRIPTION LABEL! All medication must be properly labeled and in original containers. Complete one form for each medication/treatment to be administered. A new form must be completed if the dosage of a medication changes at any time.

Nursing services are recommended for the care of this student during the school day.

It is necessary for the following medication/treatment to be given in school and during school sponsored activities. I am aware that non-medical personnel may administer this medication/treatment.

Name of medication/treatment: _____ **Amount (Dosage):** _____
Time to be given: _____ **Date to start:** _____ **Date to end:** _____
Health condition requiring medication: _____
Possible side effects: _____
Special instructions: _____
Physician ordering medication: _____
(please print)

Physician address: _____
Physician's phone: **Fax:**

Physician's signature: **(required for all medications)** _____ **Date:** _____

PARENT to Complete: Authorization for Health Care Provider and School Nurse to Share Information

I authorize my child's school nurse to assess my child as regards his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

As the parent or guardian of the student named above, I request that the principal or principal's designee assist in the administration of medication/treatment prescribed for my child.

I understand that under provisions of Florida Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them. I authorize the physician to release information about this condition to school personnel.

_____ _____ _____
Parent/Guardian Signature **Print Name** **Date**

EMERGENCY MEDICATION (INHALER/EPINEPHRINE)—Florida Statute 1002.20

*Florida law states a student may carry a metered dose inhaler or epinephrine auto-injector on his/her person and self-administer while in school with approval from his/her parents **and** physician.*

The above named child may carry and self-administer his/her emergency medication.

Parent/Guardian signature: _____ Date: _____
Physician's Signature:
(required) _____ Date _____

ST. JOHNS COUNTY SCHOOL DISTRICT

HEALTH SERVICES **DAILY MEDICATION LOG**

Student: _____ Date of Birth: _____ Teacher/Grade: _____

Medication: _____ Dose and Time: _____

Medication Counts

Date	Count	Initial	Initial	Date	Count	Initial	Initial

Administration Log

Date	Time	Initial	Date	Time	Initial

Signature Log

Initials	Name	Initial	Name