# ST. JOHNS COUNTY SCHOOL DISTRICT
## AUTHORIZATION TO ASSIST IN THE ADMINISTRATION OF MEDICATION/TREATMENT

**Student's Name:** _____ **Date of Birth:**_____

**School:** _____ **Grade:** _____ **Teacher/Homeroom:** _____

**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:** _____
(Print)

**Physician's address:** _____

**Physician's phone:** _____**FAX:** _____

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

**THIS SECTION FOR PARENT/GUARDIAN TO COMPLETE:**

*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 | Work/Home/Cell Phone | 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:_____