THE SCHOOL DISTRICT OF VOLUSIA COUNTY
HEALTH SERVICES

AUTHORIZATION TO ADMINISTER PRESCRIPTION/ NON-PRESCRIPTION MEDICATION (TO STUDENTS BY SCHOOL PERSONNEL)

NOTE: SCHOOL BOARD POLICY REQUIRES THAT:

1. Prescription medication can only be administered at school when failure to take such medication could jeopardize a student's health.

2. Medication must be brought to school by the parent/guardian or their adult designee. It must be in the original container labeled by the pharmacy to include the following, and must exactly match the doctor's orders:

   A. NAME OF STUDENT
   B. NAME OF DOCTOR (Licensed and authorized by Florida law to order prescription medication)
   C. NAME OF MEDICINE
   D. INSTRUCTION AS TO DOSAGE (amount and time, such as 12:00 PM, noon, or lunchtime)
   E. INDICATION OF SPECIAL STORAGE, IF NEEDED (refrigeration, etc.)

***** PLEASE COMPLETE ALL AREAS *****

DOCTOR'S AUTHORIZATION (To be completed by doctor) **ONLY ONE PRESCRIPTION DRUG PER FORM**

_______________ _______________ _______
Student's Name School Grade

The above student is under my medical supervision. I have ordered ____________________
(All PRN medication orders must note frequency) (Name of Medication)

DOSAGE **EXACT TIME**
________ at ________
________ at ________

Reason for medication to be administered at school: ____________________
Possible reactions or side effects: ____________________

This authorization is valid for this school year only unless earlier date is specified:________

_______________ _______________ ________ ________
Doctor's Stamp Doctor's Signature Phone Date

____
Address City State Zip

PARENT/GUARDIAN PERMISSION

I hereby request that my child be given the above medication while in school and away from school for school activities. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinarily reasonable prudent person should have acted under the same or similar circumstances.

☐ Yes ☐ No I give permission for the physician and school district personnel to exchange pertinent information pertaining to this child's condition/progress.

Signature of Parent/Guardian: ____________________

_______________ _______________
Parent/Guardian's Name (Printed) Address

_______________ ________
Nursing Supervisors Signature Date

SCHOOL SHOULD RETAIN THIS FORM IN THE HEALTH CLINIC
Distributed by: Health Services
Revised 04/2014

2004-347-VCS