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 DRUG PER FORM**

Student's Name ______ School ______ Grade ______

The above student is under my medical supervision. I have ordered ______ (Name of Medication)

DOSAGE		**EXACT TIME**
______	at	______
______	at	______

Reason for medication to be administered at school: ______

Possible reactions or side effects: ______

Date this prescription expires: ______

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.

Signature of Parent/Guardian: ______

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

Home Phone Number ______ Emergency Phone Number ______ Business Phone ______

School Nurse Supervisors Signature ______ Date ______

SCHOOL SHOULD RETAIN THIS FORM IN THE HEALTH CLINIC

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