THE SCHOOL DISTRICT OF VOLUSIA COUNTY
HEALTH SERVICES

AUTHORIZATION FOR STUDENT TO SELF-CARRY/SELF-ADMINISTER EPINEPHRINE AUTO-INJECTOR

NOTE: SCHOOL BOARD POLICY REQUIRES THAT:

1. Prescribed medication can only be self-carried at school when failure to take such medication could jeopardize a student's health.
2. Students may carry an epinephrine auto-injector for self-injection/school personnel administration, If:
   A. This form is signed by a parent or guardian.
   B. The doctor who prescribed the medication competes and signs the Doctor's Authorization below.
   C Physician determines if student can self-administer medication (In the event the student is unable to self Administer, school personnel will perform medication administration.)
3. D. Prescription medication must be brought to school by the student for whom it was prescribed. It must be in the original container labeled by the pharmacy to include the following information:
   A. NAME OF STUDENT
   B. NAME OF DOCTOR (licensed and authorized by Florida Law to order prescription medication)
   C. NAME OF MEDICINE
   D. INSTRUCTIONS AS TO DOSAGE

***** 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:

_____ Self-Administer: Yes No

Date this prescription expires: _____

_____ _____ _____
Doctor's Stamp Doctor's Signature Date Phone

_____
Address City State Zip

*******PARENT'S STATEMENT Student Can Self - Administer Yes: _____ NO____**

I request that the above- named student be authorized to self-administer the following prescription medication while in attendance at school and school activities. I will assume full responsibility for my child's self-administration and for any side effects and complications my child may have as a result of taking this medication. In addition, I assume full responsibility for any ramification that result from my child's possession of this medication. I understand that it is my obligation to ensure that the medication is not kept beyond its effective date. I agree to indemnify and hold the health department and school board, its employees and assets harmless from any and all liability or damages that may occur due to my child's possession, handling, administration, or lack of safekeeping of said medication. I agree, in the event, if my child is deemed unable to administer medication by a physician or in event of an emergency situation student is not able to self- administer medication school personnel will administer medication.

Signature of Parent/Guardian: _____

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

_____ _____ _____
Home Phone Number Emergency Phone Number Business Phone

_____ _____
School Nurse Supervisor Signature Date

SCHOOL SHOULD RETAIN THIS FORM IN THE HEALTH CLINIC