THE SCHOOL DISTRICT OF VOLUSIA COUNTY HEALTH SERVICES

AUTHORIZATION FOR STUDENT ADMINISTERED PRESCRIPTION / NON PRESCRIPTION MEDICATION

NOTE: School Board Policy requires that:

1. Prescribed medicine can only be administered or self-administered at school when failure to take such medication could jeopardize a student's health.

2. Students may self-administer prescribed medication at school or away from school on official school business when:

   A. This form is signed by a parent or guardian.
   B. The doctor who prescribed the medicine completes and signs the Doctor's Authorization below.

3. 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. INSTRUCTION AS TO DOSAGE

PARENT'S STATEMENT

______________________________ __________________________ _______
Student's Name School Grade

I request that the above-named student be authorized to self-administer the following prescription medication while in attendance at school. I will assume full responsibility for my child's self-administration of such medication and for any side effects and complications my child may have as a result of taking this medication, thereby releasing school personnel and the School Board from all liability.

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

____________________________________ _______________________
Parent/Guardian Signature Date

______________________________________ ______________ ____________
Address Home Phone Business Phone

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

DOCTOR'S AUTHORIZATION (TO BE COMPLETED BY DOCTOR) ONLY ONE DRUG PER FORM

The above student is under my medical supervision. I have ordered________________________of
________________________________. (Dosage Amount and Frequency)
Name of Medication

POSSIBLE REACTIONS OR SIDE EFFECTS: ______________________________________
REASON FOR MEDICATION TO BE ADMINISTERED AT SCHOOL:
____

I UNDERSTAND THAT THIS STUDENT WILL SELF-ADMINISTER THE MEDICATION.

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

____________________ ____________________ ____________ ____________
Doctor's Stamp Doctor's Signature Phone Date

___________________________ ________________
School Nurse Signature Date

SCHOOL SHOULD RETAIN THIS FORM IN THE HEALTH CLINIC

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