Medical Authorization

The following section is to be completed by the **PARENT/GUARDIAN** for the administration of medication. Medications must be in original containers.

Child's Name:_____ _____ _____
Last First Sex Date of Birth

_____ (____) _____
Physician's Name Address Telephone

Authorization and Informed Consent

I deliver the medicine(s) described below to **Name of School** ("School") to be held for use by my child in accordance with the instructions given below. I hereby consent and authorize the School, its administrators, teachers, and designated employees to store, supervise, and, when indicated, administer the medication(s) described in this form in accordance with the prescribing healthcare provider's instructions.

I acknowledge that a nurse may not be assigned to this campus, and that supervision or assistance may be performed by trained, non-nurse personnel under the nurse's general direction and under authority provided by state law. I further acknowledge that staff act in good faith, and that emergency care rendered in good faith is afforded protection under the Florida Good Samaritan Act (§ 768.13, Fla. Stat.). I consent to the School taking all actions reasonably deemed necessary to safeguard my child's health, including contacting the prescribing healthcare provider, consulting with emergency medical personnel, and authorizing treatment pursuant to § 743.0645, Fla. Stat., if I cannot be reached.
I assume full responsibility for providing medication and supplies in original, properly labeled containers, for monitoring expiration dates, and for promptly replacing medication or supplies as required. I agree to indemnify and hold harmless the School and its employees from claims or costs arising out of my failure to do so, or arising from medication or supplies that are mislabeled, defective, or expired. I understand and acknowledge that there are risks inherent in the self-administration of medication, including hypoglycemia, hyperglycemia, device malfunction, and allergic reaction, even when medication is taken in accordance with physician orders and with reasonable care. This authorization reflects my agreement and informed consent for the School and its employees to act in reliance on this authorization.

Administration Plan (check all that apply):

☐ Student will self-administer independently (competency confirmed by physician and parent)
☐ Student will self-administer with staff observation
☐ Trained school personnel will administer/assist as needed

Acknowledgment: I have read and reviewed the School's medication policy and agree to comply with its requirements.

Parent/Guardian Name(s): _____

Home Phone: _____ Emergency Phone: _____

Signature(s): _____ Date: _____

Other Emergency Contact: _____Phone: _____

The following is to be completed by the **PHYSICIAN**:

Diagnosis for which medication is given: _____

Name of Medicine: _____

Form: _____

Dose: _____

If medicine is to be given DAILY, at what time? _____

If medicine to be given "AS NEEDED," describe indications: _____

_____

How soon can it be repeated? _____

Is child authorized and competent to medicate independently? Yes ☐ No ☐

List significant side effects: _____

_____

Length of time this treatment is recommended: _____

_____

Other information: _____

_____

Physician's Name/Practice: _____

Phone: _____

Signature: _____ Date: ____/____/____

School Documentation (For Records)

Medication Receipt/Inventory:

Date Received: _____ Medication: _____ Quantity: _____ Expiration: _____

Staff Initials: _____