

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

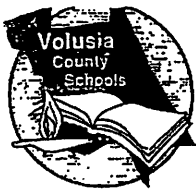
I hereby request that my child be given the above medication while in school and away from school for school activities. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication 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



DeLand
(386) 734-7190

Daytona Beach
(386) 255-6475

New Smyrna Beach
(386) 427-5223

Osteen
(407) 860-3322

EMERGENCY CARE PLAN

Student: _____ Date: _____

DOB: _____ School: _____ Grade: _____

Reason for Plan: _____ Allergies: _____

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

POSSIBLE EMERGENCY SITUATIONS:

IF YOU SEE THIS:	DO THIS:

If any of the above conditions are observed:

1. An adult is to stay with the student.
2. Notify the nurse: student's name, location of student, the problem.
3. The school nurse will assess the student and situation and decide on management.
4. If treatment interventions are not successful 911 will be called.
5. If there is no school nurse available, the following are to be notified to determine management:

Emergency Information:

Student's Home Address: _____ Phone: _____

Mother: _____ Work#: _____ Home#: _____

Father: _____ Work#: _____ Home#: _____

Other Contact: _____ Work#: _____ Home#: _____

Preferred Hospital: _____ Phone: _____

Local Hospital Emergency Room: _____ Phone: _____

Primary Physician: _____ Phone: _____

Specialists: _____ Phone: _____

_____ Phone: _____

AUTHORIZATION:

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

Parent/Guardian Date Physician Signature Date

Administrator Date Nursing Supervisor Signature Date

Emergency Care Plan should be revised according to student's specific needs.

Emergency Care plan forwarded to Transportation, Date: _____