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

SCHOOL SHOULD RETAIN THIS FORM IN THE HEALTH CLINIC
Distributed by: Health Services
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Volusia County Schools

DeLand	Daytona Beach	New Smyrna Beach	Osteen
(386) 734-7190	(386) 255-6475	(386) 427-5223	(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: _____