Medication/Treatment Authorization Form PP-SR-125
Sumter County Schools

This section is to be completed by the parent/guardian:

Student Name: _____ Gender: _____ Grade: _____ DOB: _____
Parent/Guardian Name: _____ Relationship to Student: _____
Address: _____
Home Phone: _____ **Emergency Phone:** _____ Cell Phone: _____
List student allergies: _____

I hereby grant permission to the principal or his/her designee of _____ School to assist in the administration of the prescribed medication and/or treatment to my child while in school and away from school while participating in official school activities (F.S.1006.062). **It is my responsibility to notify the school if and when these orders change.** I give permission for school district personnel and the physician to exchange pertinent information pertaining to my child's condition/progress. I authorize the School Nurse to contact the prescribing healthcare provider for clarification, if needed.
Parent/Guardian Signature: _____ Date: _____
Parent/Guardian Name (Print) _____ Date: _____

The following section is to be completed by the prescribing health care provider:

A separate form must be completed for <u>each medication or treatment prescribed</u>.
The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following medication/treatment, **which is necessary to be given in school.** I am aware that trained non-medical staff may administer this medication/prescribed service.
This order is to be effective for the school year: 20_____ - 20 _____, OR earlier stop date _____

Diagnosis/Treatment:
Name of medication: Strength: (i.e. mg/tab)
Instructions: Give: **Amount** (i.e. # of tablets or teaspoon) _____ **Exact time (**i.e. lunchtime, noon**)** _____ **Frequency** (i.e. every 6 hrs) _____ **Duration** (i.e. for 5 days, school year)_____ **ALL PRN medication orders must note frequency** _____
Route (please circle) Oral Topical I.M. Subcutaneous Inhaled Other (describe) _____
Possible side effects:
Special instruction when administering medication: (i.e. take with food, give after meal, requires refrigeration etc.)

	(Please circle)	
Is student authorized to carry and use the Asthma inhalation medication and/or Epinephrine Auto Injector?	**YES**	**NO**
Has student been instructed on the use of asthma inhaler and/or epinephrine auto injector?	**YES**	**NO**
Is student authorized to self-administer pancreatic enzymes?	**YES**	**NO**
Has student been instructed in the use of pancreatic enzymes?	**YES**	**NO**

Other information
Health Care Provider (print) _____ Address _____ Phone _____ Fax _____ Provider Signature_____ Date _____
Medication **<u>order reviewed</u>** by school RN _____ Date _____ Medication **stopped** by Parent/Guardian _____ Date _____

REV: 6/16

MEDICATION/TREATMENT AUTHORIZATION FORM

Instructions: For medical/treatment administration during school hours.

Medication refers only to those products which have been approved by the "Food and Drug Administration" (FDA) for use as a drug.

If your child needs to have medication(s)/treatment(s) given during the school day, state regulations and school board policy require that you and your health care provider provide written permission for administration of both prescribed and over-the-counter medication(s) and treatment(s).

♦ **Prescribed medications** must arrive in a container with the original, unaltered prescription label attached. **The label must display all legal information required for a pharmacist to dispense a prescription medication such as valid issue and expiration dates, the patient's name, the medication name and dosage instructions, and the provider's name. You should ask the pharmacy for a bottle for school and a bottle for home.** ***The label information must match the health care provider's order on the "Medication/Treatment Authorization form" (PP-SR-125).***

♦ **Over-the-counter medications** must arrive in the original, **unopened** store-issued container. You may want to label the container with your child's full name and it must be accompanied by the ***health care provider's order on the "Medication/Treatment Authorization form" (PP-SR-125).***

♦ The Medication/Treatment Authorization Form must be completed entirely and accompany any medication **(either prescribed or over-the-counter)** to be given to your child in school. **Both a parent/legal guardian and the prescribing provider must sign the form.** Staff will not be able to administer medications to your child without this **written consent**.

♦ The parent, legal guardian, or an authorized adult must hand carry medications to the school health room. The medication brought into the school health room must match the prescribed medication amount. For example, if the prescribed amount is ½ tablet, then it is the responsibility of the pharmacy/parent to cut the tablets. The school health staff, upon receipt will verify the quantity of each medication. **Albuterol and Epinephrine Auto-Injectors must be delivered in the original box with the pharmacy label.** **Do not send medications to school with your child.**

♦ **The RN at your child's school may need to call the doctor's office for medication/treatment clarification.**

The parent/legal guardian will need to pick up the medication at the end of the school year, if the medication is discontinued or changed during the school year, or if the medication has expired. If the medication is not picked up by the parent within 4 weeks of expiration or discontinuation date the medication may be discarded by school health staff. At the end of the school year, **medication not picked up within the next 2 days after school is out, will be discarded.**