DUVAL COUNTY PUBLIC SCHOOLS
MEDICATION ADMINISTRATION AUTHORIZATION

ONE MEDICATION PER FORM

TO BE FILLED OUT BY HEALTH CARE PROVIDER

Student _____ DOB ___/___/_____ School Year _____

Name of Medication _____ Dose_____ Specific Time _____

Route □ by mouth □ inhaled □ injection □ other: _____ ICD10 Code _____

Health Condition Requiring Medication _____

Allergies _____ Known Side Effects _____

Special Instructions _____

I have determined that it is medically necessary for this medication to be provided during the school day for the above named child.
(If you have determined the child needs to self-carry one of the medications listed below, please also sign the bottom section of this form)

___/___/___	_____	_____	_____
Date	Signature of Health Care Provider	Provider Name or Office Stamp	Provider Phone #

Parent/Legal Guardian Authorization

I authorize the principal or principal's designee to assist in the administration of the medication for my child (named above). I certify that the prescribed medication is in its **original prescription or unopened over-the-counter container** and that it is medically necessary, according to the health care provider's instructions, for this medication to be provided during the school day, including when my child is away from school property on official school business. I understand this **medication will be given only according to the directions written by the health care provider**. I agree to waive any claims of liability that may arise against any school personnel relative to the administration of medication to my child according to these directions. I authorize my child's nurse or district medical personnel to discuss my child with the prescribing health care provider's office or health care provider as needed throughout the school year. **I further understand that, at the end of the school year, it will be my responsibility to pick up any unused medication by the last day of the school year, otherwise the school will dispose of the medication.**

___/___/___	_____	_____	_____
Date	Signature of Parent/Legal Guardian	Name or Parent/Legal Guardian	Phone #

STUDENTS WHO ARE AUTHORIZED TO SELF CARRY MEDICATION

(anaphylaxis supplies, rescue inhalers, diabetic supplies, and pancreatic enzymes)

My child is required to self-carry this medication during the school day. I understand this means my child will be self-administering this medication and the school staff is not responsible for monitoring the administration. I understand that I am responsible for ensuring that my child has this medication during the school day, including when the student is away from school property on official school business. I will ensure the medication my child carries is properly labeled and not expired.

___/___/___	_____	_____
Date	Signature of Parent/Legal Guardian	Name or Parent/Legal Guardian

I understand that I am to self-carry my medication and to determine when I need to use the medication. I will not allow any other student to use my medication. I will notify an adult of any symptoms I experience during the school day.

___/___/___	_____	_____
Date	Signature of Student	Name or Student

It is necessary for this child to self-carry this medication during the school day. The child is knowledgeable of when and how to use the medication.

___/___/___	_____	_____
Date	Signature of Health Care Provider	Provider Name or Office Stamp

MEDICATION GUIDELINES

A. Administration of Prescription and Non-Prescription Medication

1. Whenever possible, medication schedules should be arranged so all medication is given at home.
2. Medication must be delivered to the school by the parent/guardian in the **original prescription or unopened over-the-counter container** and the Medication Administration Authorization form must be signed by the parent/guardian and health care provider (Medical Doctor, Physician Assistant, or Advanced Practice Registered Nurse).
3. Medication Administration Authorization forms must be completed and signed by parent or guardian and health care provider for **each medication** given.
4. A **new** Medication Administration Authorization form is required **each school year** and when there is a change to the medication.
5. The medication label must indicate the student's name, medication name, health care provider's name, dosage, time to administer, and expiration date.
6. If the medication requires special equipment for administration, the parent must supply the necessary item.
7. All medications to be administered by school personnel shall be **received**, **counted** and **stored** in original containers. When a medication dose is given to a student, it **must be recorded**. If dosage is not recorded, it will be assumed that the student did not receive the required dose.
8. When the medication is not in use, it shall be stored in its original container in a secure fashion **under lock and key** in a location designated by the principal.
9. At the end of the school year, medication not picked up will be destroyed after the last day of school.

B. Self-Carry Medication

1. Once a Medication Administration Authorization form is completed by the parent, student and health care provider indicating the need for the student to self-carry a medication is on file at the school, the student may carry the following medications: rescue inhaler, anaphylaxis supplies, diabetic supplies, and pancreatic enzymes.
2. School staff is not responsible for monitoring the administration of self-carry medication.
3. It is the parent or guardian's responsibility to ensure that the student has their medication during the school day and that the medication is properly labeled and not expired.