School _____ **Grade** _____

DUVAL COUNTY PUBLIC SCHOOLS
MEDICATION ADMINISTRATION AUTHORIZATION

Student _____ DOB __/___/___ Allergies _____

Name of Medication _____Dose _____ Time _____

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

Reason to be administered _____

Special instructions _____

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 container** and that it is necessary, according to my physician'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 on the label as prescribed by the doctor**. Further, 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 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 Parent/Legal Guardian Phone #

I have determined that it is 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 this medication, please also complete the section at the bottom of this form.)**

___/___/____ _____ _____
Date Signature of Health Care Provider Provider Phone #

STUDENTS WHO ARE AUTHORIZED TO SELF CARRY MEDICATION
(Epinephrine, 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

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

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 Phone #