St. Johns Classical Academy
PARENTAL AUTHORIZATION FOR ADMINISTRATION OF MEDICINE
(File in PTR folder for seven years)

Over The Counter (OTC) Medications

SCHOOL YEAR:

- Name		- Medication Name	
- DOB		- Dose/Route/Time	
- Grade/Teacher		- Medication **Start** Date	
- Age		- Medication **End** Date	
- Allergies		- Physician Name & Number	
- **Reasons for Medication to be given:**			

As parents/guardians of the scholar named above, I request St. Johns Classical Academy (SJCA) or its assigned designee to administer the above medication to my scholar. OTC medication administration at school is for a limited time only and for a PRN (as needed) basis only.

I understand that under the provision of Florida Statute 1006.062, school personnel cannot be held liable for reactions or effect from the administration of the medication. I hereby release, indemnify, and hold harmless SJCA and any of their officers, employees, contractors, and agents from any lawsuits, claims,

TO BE COMPLETED BY PARENTS / GUARDIANS

the physician named above if there are questions or concerns about the medication or health condition, or for the purpose of generating a health care plan for my scholar, as allowed by HIPAA. I have read the guidelines and agree to abide by them.

In addition, I understand:

1. The OTC medication will be in its **original container**, unexpired, unopened, and labeled with the scholar's name.
2. The medication will be **given per label and cannot exceed dose specified on medication label without a physician's order.**
3. Medication must be ***brought to the school by a parent/guardian***, not by the student.
4. A separate Parental Authorization for Administration of Medicine form must be completed for each medication and is valid for the current school year in which it is completed.
5. Each child (including siblings) receiving medication should have their own supply of medication.
6. Medications containing aspirin (Excedrin, Goody Powder, etc.) will not be accepted without a physician's written order, due to the association with Reye Syndrome.
7. Only FDA approved prescribed and OTC medicines will be accepted. No vitamins, nutritional supplements, etc.
8. Medications and doses of medication must be age appropriate. Some non-prescription medications are not recommended for children. Check the box/bottle for this information prior to bringing it to the school.
9. I understand the possible side effects of the said above medications.
10. 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. Expired medication should be picked up within two (2) weeks of expiration date or it will be discarded.

I have read the guidelines and agree to abide by them.

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Parent/Guardian Name (Print) and Signature | Relationship | Phone Number | Date

EXCEPTION: HEADACHE MEDICATION

In accordance with Florida Statute a student may possess a medication to relieve headaches without a physician's order if the medication is regulated by the USDA for over-the-counter use to treat headaches while on school property or at school sponsored events. It is our recommendation and best practice for scholars to take medications in the health rooms only. At this time, we only recommend High School (9-12th grade) scholars to self-carry headache medication. It must be kept in its original container, not contain aspirin, and a copy of this PAAM must always be with the medication. The scholar is not allowed to share the medication with any other individual while on campus and/or at a school event. If a scholar is found to be unreliable, abusive of the medication, or if they share the medication with other scholars, the self-carry privilege will be revoked and reported to administration. This could result in disciplinary consequences for the scholar.

Scholar may self-carry **headache medication** in High School (Parent Signature): _____

Scholar **May Not** self-carry **headache medication** in High School (Parent Signature): _____

I understand my responsibility of self-carrying the above OTC headache medication (Scholar Signature): _____

TO BE COMPLETED BY HEALTH ROOM

Nurse Name and Signature | Date