St. Johns Classical Academy

PARENTAL AUTHORIZATION FOR ADMINISTRATION OF MEDICINE

File in PTR folder for seven years.

Prescribed Medication

SCHOOL YEAR:

	Print Only		**Print Only**
- Name		- Medication Name	
- DOB		- Dose/Route/Time	
- Grade/Teacher		- Prescriber Name	
- Weight		- Prescriber Phone	
- Health Condition		- Medication **Start** Date	
- Allergies		- Medication **End** Date	

TO BE COMPLETED BY PARENTS / GUARDIANS

As parent/guardian of the scholar named above, I request that St. Johns Classical Academy (SJCA) or it's assigned designee administer the medication described above to my child.

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, demands, expenses, or actions against them on behalf of myself, my spouse/co-parent/co-guardian, and my named scholar regarding any and all injuries, losses, or damages my named scholar may sustain from the administration of the above medication. I also grant permission for school personnel to contact 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. Medication must be in its ***original container with the pharmacy labeled attached, not expired, and unopened***.
2. Medication must be brought to the school ***by a parent/guardian***, not by the student.
3. Medication will only be administered during school hours ***when the schedule cannot be adjusted to allow for administration at home*** and will be given per physician's instructions/orders only.
4. If any changes in medication/dosage occur during the school year, a new form must be completed along with a new pharmacy-labeled container and returned to the school.
5. Only one form per medication. Each child (including siblings) receiving medications will have their own supply of medication and separate forms.
6. 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.
7. At the end of the school year, it will be our/my responsibility to pick up any unused medication by the last day of the school year; otherwise, the school will dispose of the medication.
8. Expired medication should be picked up within two (2) weeks of expiration date or it will be discarded

Parent/Guardian Name (printed): _____

Signature: _____ Date: _____

Email: _____ Phone: _____

TO BE COMPLETED BY PHYSICIAN / HEALTH CARE PROVIDER

I have determined that it is necessary for this medication to be provided during the school day for the above-named scholar.

Healthcare Provider Signature: _____Date:_____

*****(If you have determined that the scholar needs to **self-carry this medication**, please also complete the section on the back of this form.)******

(For Self-Carry Students: See Back of this Form)

** STUDENTS WHO ARE AUTHORIZED TO SELF-CARRY PRESCRIPED MEDICATION **

(Epinephrine, Inhalers, Diabetic Supplies, Pancreatic Enzymes)

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

Healthcare Provider Signature: _____Date:_____

TO BE COMPLETED BY PARENTS / GUARDIANS

I certify that my scholar is **required to self-carry** the medication named above during the school day. I understand that this means ***my scholar will be self-administering this medication*** and that ***school staff is not responsible for monitoring administration***. I understand that ***I am responsible for ensuring that my scholar has this medication during the school day***, including when the scholar is away from school property on official school business. I will ensure that the medication my scholar carries is properly labeled and not expired. I understand that if a scholar who is self-carrying medication is found to be unreliable, abusive of the medication, or have shared the medication with another scholar, it will be reported to administration and could result in disciplinary actions.

Parent/Guardian Name (printed): _____

Signature: _____ Date: _____

TO BE COMPLETED BY SCHOLAR

I understand that I am to self-carry the medication named above and that I am to determine when I need to use the medication. I will notify an adult of any symptoms I experience during the school day. I will tell a member of the school health clinic staff when I use my medication. I will not allow any other scholar to use my medication. I understand that I can and will be reported to administration if I share this medication with another scholar.

Scholar Name (printed): _____

Signature: _____ Date: _____

TO BE COMPLETED BY HEALTH ROOM STAFF

The above-named scholar has demonstrated proper medication administration techniques.

School Nurse Name (printed): _____

Signature: _____ Date: _____