PINELLAS COUNTY SCHOOLS
SCHOOL HEALTH SERVICES
AUTHORIZATION TO CARRY AND SELF ADMINISTER MEDICATION

STUDENT NAME: _____ DATE OF BIRTH: _____

SCHOOL: _____ GRADE: _____

PARENT NAME: _____ TELEPHONE: _____

I. PARENT/GUARDIAN PERMISSION:

I hereby request and give permission for my child to be allowed to carry and/or self-administer the medication marked below by physician initials per Florida Statute while in school and away from school for school-related activities. Administration will be in compliance with written directions from my child's physician per the medication prescription. I will notify the school immediately if the health status of my child changes, we change physicians, we change home, work or emergency telephone numbers, or there is a change or cancellation of the medication order. I understand it is my responsibility to ensure that my child has the proper medication, that it is within the expiration date for his/her use, and that the delivery system is functioning properly. I understand that no other medications other than those listed below are allowed to be carried by my student. In the event that my child would exhibit symptoms requiring the medication below while being transported by a school bus, the bus driver/school district personnel will not administer the medication, but will call for emergency medical assistance as soon as they become aware that the situation requires it. I acknowledge that the school nurse is authorized to provide training to any school personnel as required, and that the school nurse has the authority to revoke the self-administration privilege for any student the nurse may assess as unsafe or ineffective in his/her professional judgment. I recognize that my student may carry only one epinephrine device on their person. If my student can self-administer, it is strongly encouraged that a back-up supply of medication is provided to the school clinic. I understand that if my student cannot self-administer their own medication, I must provide a back-up supply for the school clinic.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

II. PHYSICIAN STATEMENT:

The above named student may carry and/or self-administer the following medication as outlined below *(please mark all boxes that are applicable and initial to the right of all marked boxes)*:

Metered Dose Inhaler (MDI) ☐ Student may carry ☐ Student may self-administer *Initials:* _____

Epinephrine for Severe Allergy ☐ Student may carry ☐ Student may self-administer *Initials:* _____

NOTE: If Epinephrine is used, 9-1-1 MUST be activated!

Pancreatic Enzyme Supplement ☐ Student may carry ☐ Student may self-administer *Initials:* _____

PHYSICIAN SIGNATURE: _____ DATE: _____

PHYSICIAN NAME *(please print)*: _____ TELEPHONE: _____

III. REGISTERED NURSE STATEMENT:

I acknowledge that the student named above is authorized to carry and/or self-administer the indicated medication, and it is my professional judgment that this student can safely and effectively carry and/or self-administer this medication.

REGISTERED NURSE SIGNATURE: _____ DATE: _____

REGISTERED NURSE NAME *(please print)*: _____

A NEW AUTHORIZATION IS REQUIRED EACH SCHOOL YEAR