Okeechobee County School Health Services

PHYSICIAN'S AUTHORIZATION FORM

Daily and As Needed Medication

Name of Student: _____ **DOB:** _____ **Date:**_____

Part I: To be completed by physician's office; one medication per form

It is necessary for the medication listed below be given during school hours:

[ ] DAILY MEDICATION [ ] PRN MEDICATION [ ] EMERGENCY MEDICATION

Medication:_____ Dosage:_____ Route:_____

Form (please circle): Pill/Tab Capsule Liquid Other_____

Specific time(s) daily medication is to be administered: _____

Frequency for as needed medication: _____ Medication ordered for:_____

Any special instructions: _____

For student with severe allergy: The student has had allergic reactions to the following: (please be specific)

Food _____ or Insect _____

Other _____

Epinephrine should be administered under the following "specific" conditions:

[ ] Immediately post exposure to the allergen

[ ] Administer only if the following reactions occur: (please check all that apply)

[ ] Shortness of Breath/Wheezing [ ] Hives/Full Body Rash [ ] Generalized Swelling/Edema

[ ] Anxiousness, Cannot Swallow/Verbalize [ ] Other _____

Self-carry and Administer Authorization:

[ ] **Student permitted to carry inhaler [ ] Student permitted to carry epinephrine** [ ] **Student permitted to carry pancreatic enzymes**

According to Florida statutes students are allowed to carry and self-administer Rescue Inhalers, Epinephrine auto injectors, pancreatic enzymes, diabetic supplies and equipment. I believe that this student has received adequate information on how and when to use their medication and they can use it properly. The student is to carry the medication on their person with the principal's knowledge. (An additional supply, to be used as backup, may be kept in the school clinic). If the student is not authorized to carry by the health care provider and the parent/guardian, the medication will be kept in the school clinic.

_____	_____	_____	_____
Physician Name (please print)	**Physician Signature**	**Date**	**Office Number**

Part II: To be completed by Parent/Guardian (español en la espalda**)**

I authorize the principal or principal's designee to assist or perform the administration of the medication for my child. I certify that the prescribed medication is in its original container and that it is medically necessary, according to my physician's instructions, for this medication to be provided during the school day and when my child is on a field trip for educational purposes (which can extend beyond normal school hours). I understand this medication will be given only according to the directions on the Physician's Authorization Form as prescribed by the doctor. 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.

I authorize the school nurse to share information with appropriate school staff relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety and to contact the above health care provider for information relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.

If indicated by the physician, that the medication be self-carry, I give my permission for my child, named in part I, to self-administer the medication. A licensed health care provider has prescribed this medication, and my child has been instructed on its use.
If, for any reason, my child is unable to inject himself/herself with the epinephrine, or is unable to make the decision himself/herself as to whether the epinephrine is needed, I give my permission for an adult school staff member who has been trained regarding emergency epinephrine injection to assist my child in the decision and/or administration of the epinephrine. I also understand that, if my child must administer the epinephrine, emergency services (911) will be called for follow-up treatment.

_____	_____	_____
Parent/Guardian Signature	**Parent/Guardian (Print Name)**	**Date**

Okeechobee County School Health Services

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Daily and As Needed Medication

Part II: Para ser completado por el padre/guadrdian

Autorizo al director o a la persona designada por el director a ayudar o realizar la administración del medicamento para mi hijo. Certifico que el medicamento recetado está en su envase original y que es médicamente necesario, de acuerdo con las instrucciones de mi médico, que este medicamento se proporcione durante el día escolar y cuando mi hijo esté en una excursión con fines educativos (que puede extenderse más allá del horario escolar normal). Entiendo que este medicamento se administrará únicamente de acuerdo con las instrucciones del Formulario de autorización del médico según lo prescrito por el médico. Además, entiendo que, al final del año escolar, será mi responsabilidad recoger cualquier medicamento no utilizado antes del último día del año escolar; de lo contrario, la escuela se deshará del medicamento.

Autorizo a la enfermera de la escuela a compartir información con el personal escolar apropiado relevante a la administración de medicamentos recetados según lo determine apropiado para la salud y seguridad de mi hijo/hija y a comunicarse con el proveedor de atención médica mencionado anteriormente para obtener información relevante a la administración de medicamentos recetados según lo determine quees apropiado para la salud y seguridad de mi hijo.

Si el médico lo indica, que el medicamento sea autoadministrado, doy mi permiso para que mi hijo/hija, mencionado en la parte I, se autoadministre la medicacion. Un proveedor de atención médica autorizado le recetó este medicamento y mi hijo/hija recibió instrucciones sobre su uso. Si, por alguna razón, mi hijo no puede inyectarse epinefrina por sí mismo, o no puede tomar la decisión por sí mismo sobre si la epinefrina es necesaria, doy mi permiso para que un miembro del personal de la escuela para adultos que haya sido capacitado sobre la inyección de epinefrina de emergencia para ayudar a mi hijo en la decisión y/o administración de la epinefrina. También entiendo que, si mi hijo/hija debe administrar epinefrina, se llamará a los servicios de emergencia (911) para recibir tratamiento de seguimiento.

_____	_____	_____
Firma del Padre / Guardian	**Padre / Guardian (Imprimir nombre)**	**Fecha**

Part IIII: School Use Only

Reviewed by: _____ _____

School Health Personnel — Date

_____ _____

School Nurse — Date