Episcopal Day School
223 N Palafox Street
Pensacola, FL 32502
Phone: 850-434-6474
Fax: 850-434-6560

episcopal
DAY SCHOOL
Summer Camp

Authorization for Assisted Student Self-Administration of NON-Prescription Medication
Summer Camp 2017

Student's Name (Last, First) Birth Date Grade

Parent/Guardian Address Cell phone# Work phone#

Medications Provided for Assisted Student Self-Administration:

MEDICATION DOSAGE AMOUNT

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I request the designated school personnel to assist my child in the administration of the above described medication/s. I give permission for my child to take the medication indicated according to the condition /symptoms described while in school or while participating in school activities away from the school site.

I understand that:

- The policies and procedures employed for assisting student self-administration of non-prescription medications are consistent with the recommendations of Escambia County Health Department.
- A separate authorization form must be filled out for EACH student.
- There is no liability on the part of the school, its personnel, or agents, including Escambia County Health Department personnel, for civil damages as a result of the administration of this medication to my child when the person assisting the student with self-administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances.
- OTC medications will be brought from home and labeled with student's name as designated on this authorization.
- I will be contacted if my child's symptoms do not improve and s/he is unable to remain at school.
- Students are not allowed to bring or carry any over-the-counter medications to school or school-sponsored activities

Parent/Guardian Signature:_____ Date:_____

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Authorization for Assisted Student Self-Administration of Prescription Medication
Summer Camp 2017

A separate form must be used for each prescription medication.

Please return the completed form to the school office.

STUDENT INFORMATION (To Be Completed By Parent/Guardian).

Student's Name (Last, First, Middle) _____ Birth Date _____ Grade _____

Parent/Guardian _____ Address _____ Allergies _____

Home Phone _____ Work # _____ Cell # _____

THIS REQUEST IS TO BE EFFECTIVE FOR SUMMER CAMP 2017

NAME OF MEDICATION/STRENGTH: _____ DOSAGE: _____

TIME TO BE ADMINISTERED AT SCHOOL: _____

FREQUENCY: _____ REASON FOR TAKING THE MEDICATION: _____

POSSIBLE SIDE EFFECTS: _____

PHYSICIAN PERMISSION (To be completed ONLY if student is to carry and/or self administer medication.)

Florida law only allows students with asthma, life-threatening allergic reactions, diabetes, pancreatic insufficiency or cystic fibrosis, **with parent and physician authorization,** to carry and self-administer the prescribed type of medication as below.

s. 1002.20(3)(h), FS Inhalant

s. 1002.20(3)(i), FS Epinephrine Auto-Injector

s. 1002.20(3), FS Prescribed Pancreatic Enzyme

s. 1002.20(3)(j), FS Diabetes Medication and Supplies

This student is both capable and responsible for ☐ carrying and/o ☐ self-administering this medication.

Print Physician's Name: _____ Address: _____

Physician's Signature: _____ Phone: _____ Date: _____

PARENTAL PERMISSION (To Be Completed By Parent/Guardian and witnessed by School staff or notarized). Form is void if this section is incomplete.

I request the designated school personnel to assist my child in the administration of the above prescribed medication. I give permission for my child to take this medication while in school or while participating in school activities away from the school site. I understand that: (1) there is no liability on the part of the school, its personnel, or agents, for civil damages as a result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances; (2) this medication must be brought to the school only by a responsible adult; (3) this medication must be in its original labeled container; (4) this medication will be destroyed if it is not picked up by the close of the current school year, whichever occurs first. I assume all risk and liability with respect to my child's use of epinephrine, including any related injection device, inhalent, insulin, diabetes supplies or prescribed pancreatic enzyme when authorizing my child to self-administer and/or carry the prescribed medication.

Print: Parent/ Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____

School Staff Signature: _____

Notary: _____

Signed before me in Escambia County, Florida, this ____ day of _____201__.

Identification:

Known by me: _____

_____

Signature of Notary

Notary Stamp

Pursuant to Section 1006.062, Florida Statute, any student who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school staff.

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Please return the completed form to the school office.

STUDENT INFORMATION (To Be Completed By Parent/Guardian).

Student's Name (Last, First, Middle) _____ Birth Date _____ Grade _____

Parent/Guardian _____ Address _____ Allergies _____

Home Phone _____ Work # _____ Cell # _____

THIS REQUEST IS TO BE EFFECTIVE FOR Summer Camp 2017

NAME OF MEDICATION/STRENGTH: _____ DOSAGE: _____

TIME TO BE ADMINISTERED AT SCHOOL: _____

FREQUENCY: _____ REASON FOR TAKING THE MEDICATION: _____

POSSIBLE SIDE EFFECTS: _____

PHYSICIAN PERMISSION (To be completed ONLY if student is to carry and/or self administer medication.)

Florida law only allows students with asthma, life-threatening allergic reactions, diabetes, pancreatic insufficiency or cystic fibrosis, **with parent and physician authorization,** to carry and self-administer the prescribed type of medication as below.

s. 1002.20(3)(h), FS Inhalant

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s. 1002.20(3), FS Prescribed Pancreatic Enzyme

s. 1002.20(3)(j), FS Diabetes Medication and Supplies

This student is both capable and responsible for ☐ carrying and/o ☐ self-administering this medication.

Print Physician's Name: _____ Address: _____

Physician's Signature: _____ Phone: _____ Date: _____

PARENTAL PERMISSION (To Be Completed By Parent/Guardian and witnessed by School staff or notarized). Form is void if this section is incomplete.

I request the designated school personnel to assist my child in the administration of the above prescribed medication. I give permission for my child to take this medication while in school or while participating in school activities away from the school site. I understand that: (1) there is no liability on the part of the school, its personnel, or agents, for civil damages as a result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances; (2) this medication must be brought to the school only by a responsible adult; (3) this medication must be in its original labeled container; (4) this medication will be destroyed if it is not picked up by the close of the current school year, whichever occurs first. I assume all risk and liability with respect to my child's use of epinephrine, including any related injection device, inhalent, insulin, diabetes supplies or prescribed pancreatic enzyme when authorizing my child to self-administer and/or carry the prescribed medication.

Print: Parent/ Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____

School Staff Signature: _____

Notary: _____

Signed before me in Escambia County, Florida, this ____ day of _____201__.

Identification:

Known by me: _____

_____ Notary Stamp

Signature of Notary

Pursuant to Section 1006.062, Florida Statute, any student who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school staff.

MEDICATION PROTOCOL AT SCHOOL
PARENT RESPONSIBILITIES

Prescription Medication

- An Authorization for Assisted Student Self-Administration of Prescription Medication must be completed and signed by the parent/ guardian for each prescription/non-prescription medication provided. Parent/guardian signature must be witnessed by school staff or notarized. This form is available in the school office. A physician signature is **only** required if the student is authorized to carry and/or self-administer the medication at school or during a school activity.
- A separate authorization form must be filled out for each prescription medication administered.
- Changes in medication require a new Authorization for Assisted Student Self-Administration of Prescription Medication signed by the parent/guardian.
- Medication must be provided in the original container.
- No more than a 30 day supply of medication may be accepted.
- A responsible adult must deliver and pick up the medications in the school office.
- Notify office staff directly of any medication changes, including discontinued medications.
- If your child is authorized to receive early morning medication at school, do not give this dose at home. Discontinued medication must be picked up by parent/guardian within one week of the stop date.
- Unclaimed medication will be destroyed one week after stop date.
- During the last month of the current school year, bring only enough medication to be used by the last day of school. Unclaimed medication will be destroyed at the close of the last day of school.