

# THE SCHOOL DISTRICT OF MARTIN COUNTY, FLORIDA PHYSICIAN AUTHORIZATION FOR STUDENT MEDICATION

**Part 1:** Must be completed by a Physician/qualified medical provider. Use one form per medication.

Student: \_\_\_\_\_ Birth date: \_\_\_\_\_ Date \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD-9 Dx code: \_\_\_\_\_

Medication (one per form): \_\_\_\_\_ Dose prescribed: \_\_\_\_\_

Route: Oral  Liquid  Other \_\_\_\_\_ Schedule (time) \_\_\_\_\_

**PRN ORDERS:** If you are ordering medication "**AS NEEDED**", please specify under what conditions the child is to take (i.e. pain): \_\_\_\_\_ Special instructions: \_\_\_\_\_

**Inhaler/Nebulizer:** Medication Name \_\_\_\_\_ Strength/Dose \_\_\_\_\_

Amount/# of puffs \_\_\_\_\_ Schedule (at what time) \_\_\_\_\_

If you are ordering the Inhaler "*as needed*" please specify under what conditions: (check all that apply)

- Shortness of Breath
- Coughing
- Wheezing
- Other \_\_\_\_\_

The student has been trained and has my permission to self-administer the MDI.

**Check One:** Student may carry inhaler  **OR** Inhaler to be kept in clinic

Medication side effects: \_\_\_\_\_

### PHYSICIAN AUTHORIZATION

Physician's Name (Print) \_\_\_\_\_ Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

License Number \_\_\_\_\_ Telephone \_\_\_\_\_ Fax Number \_\_\_\_\_

**Part 2:** Must be signed by **parent/guardian**

### Parent/Guardian Permission

***I understand that:***

- Medication orders, including over-the-counter, are valid for this school year only and need to be renewed at the beginning of each school year.
- Medication, including over-the-counter, must be in original container and labeled to match physician's order for school use including field trips.
- I have the responsibility for supplying medication and or supplies as needed.
- Medication orders become part of my child's permanent school health record.
- I give permission to 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.
- I give permission to the school nurse 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.
- I may retrieve the medication from the school at any time; however the medication will be destroyed if it is not picked up within one week following termination of the order or one day beyond the close of school.

**I hereby give permission for my child (named above) to receive medication during school hours administered by the nurse or trained principal designee. I understand the School District and School Health Program under take no responsibility for the administration of the medication. This medication has been prescribed by a licensed physician. I hereby release the School District and its agent and employees as well as the School Health Program from any and all liability that may result from my child taking the medication.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Health Assistant Signature \_\_\_\_\_ Date \_\_\_\_\_

School Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

# PHYSICIAN AUTHORIZATION FOR STUDENT MEDICATION - **EPIPEN®**

**Part 1:** Must be completed by a Physician/qualified medical provider. Use one form per medication.

Student: \_\_\_\_\_ Birth date: \_\_\_\_\_ Date \_\_\_\_\_

Diagnosis/Allergy \_\_\_\_\_ ICD-9 Dx code: \_\_\_\_\_

If a food allergy is listed, will a dietary substitution be necessary? No  Yes

**EpiPen Instructions:** The student has had a prior severe allergic reaction and must have the following at school:

EpiPen Jr. 0.15 mg  **OR** EpiPen 0.3 mg  Repeat injection: No  **OR** Yes, in \_\_\_\_\_ minutes.

**Check all that apply:**

The student has been properly trained on the use and administration of the EpiPen and will carry the EpiPen and self-administer unless unable. **OR**

Trained school staff should administer the EpiPen

**The EpiPen should be administered under the following conditions:**

Immediately post exposure to the allergen **OR**

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

- Shortness of Breath/Wheezing
- Hives/Rash
- Anxiety
- Generalized Swelling/Edema
- Other \_\_\_\_\_

Medication side effects: \_\_\_\_\_

## PHYSICIAN AUTHORIZATION

\_\_\_\_\_  
Physician's Name (Print) Physician's Signature Date

\_\_\_\_\_  
License Number Telephone Fax Number

**Part 2:** Must be signed by **parent/guardian**

### Parent/Guardian Permission

***I understand that:***

- Medication orders are valid for this school year only and need to be renewed at the beginning of each school year.
- Medication must be in original container and labeled to match physician's order for school use including field trips.
- I have the responsibility for supplying medication and or supplies as needed.
- Medication orders become part of my child's permanent school health record.
- I give permission to 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.
- I give permission to the school nurse 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.
- I may retrieve the medication from the school at any time; however the medication will be destroyed if it is not picked up within one week following termination of the order or one day beyond the close of school.

I hereby give my permission for my child to self-administer the EpiPen during school hours if needed for an allergic reaction. A licensed physician has prescribed this medication and my child has been instructed on its use. I also understand that in the event that my child must self-administer the EpiPen emergency services (911) will be called for follow-up treatment. If for any reason my child is unable to inject himself/herself with the EpiPen or unable to make the decision himself/herself as to whether the EpiPen is needed. I give permission to an adult school staff member who has been trained in emergency EpiPen injection to assist my child in the decision and/or administration of the EpiPen.

**I understand the School District and School Health Program under take no responsibility for the administration of the medication. I hereby release the School District and its agent and employees as well as the School Health Program from any and all liability that may result from my child taking the medication.**

\_\_\_\_\_  
Parent/Guardian Signature Date

\_\_\_\_\_  
Health Assistant Signature Date

\_\_\_\_\_  
School Nurse Signature Date