



# First Baptist Academy Medication Authorization Form

Student's Name: \_\_\_\_\_ Sex: M  F  Date of Birth: \_\_\_\_\_ Student #: \_\_\_\_\_

School Name: First Baptist Academy Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Allergies: \_\_\_\_\_

## MEDICATION INFORMATION

Medical Condition for which medication will be required for student in school: \_\_\_\_\_

ICD10 Code \_\_\_\_\_

Name of Medication: Prescription \_\_\_\_\_ Over-the-Counter \_\_\_\_\_

Route to administer (*please check one*)  Oral  Topical  Subcutaneous  Inhaled  IM Other \_\_\_\_\_  
(BY MOUTH) (ON THE SKIN) (INJECTED) (BREATHED)

Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Time of Day: (ex. 11:00 AM) \_\_\_\_\_

Is this a new medication?  Yes  No If yes, the first dose must be administered at home.

Special Instructions: \_\_\_\_\_

**Prescription medications require healthcare provider signature below:  
Physician's orders are required for all prescription medications given at school**

Physician's Name (Print): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Fax Number: \_\_\_\_\_

I have prescribed the student to self-carry MDI, pancreatic enzymes, EPI-PEN, or other life saving medications described on this page.

## PARENT/GUARDIAN AUTHORIZATION

1. I give permission for my child's doctor to be contacted for information regarding the administration of the medication listed on this form.
2. I authorize the above medication to be administered as described or prescribed during school or after-school programs operated by Collier County Public Schools.
3. I understand that medication not picked up by the last day of school will be discarded.
4. I understand that medication may not be administered if either the "discard after date" or the manufacturer's expiration date has passed.

Parent/Guardian Name Printed: \_\_\_\_\_

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

Home phone: \_\_\_\_\_ Business phone: \_\_\_\_\_ Emergency phone number: \_\_\_\_\_

## FOR SCHOOL NURSE USE ONLY.

Physician's Verbal Order Obtained: Date: \_\_\_\_\_ Time: \_\_\_\_\_ Received From: \_\_\_\_\_

Content of physician's verbal order obtained: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

School Nurse

**Please see reverse side of this document for Medication Authorization Information**

# First Baptist Academy Medication Authorization Form

Dear Parent/Legal Guardian:

If your child requires medication(s) during the school day, Florida Statutes and School Board Policy require that you provide written authorization for all medications to be given. An authorization for prescription medication must also be completed and signed by a physician or other health care provider licensed in the state of Florida (as outlined in Florida Statutes, F.S. 464) **(Medications not approved by the Food and Drug Administration (FDA) and alternative medications, including natural, herbal remedies, homeopathic medicines, food supplements, and vitamins may not be administered at school, with the exception of prescribed pancreatic enzymes or prescribed dietary products to treat lactose intolerance)**

- The Medication Authorization Form on the reverse side of this document must be entirely completed and accompany prescribed or over-the-counter medications to be given to your child in school. The form must be signed by a parent/legal guardian. The prescribing healthcare-provider must also complete and sign the form for any **prescription** medications to be given. **Medications will not be administered without a completed Medication Authorization Form.**
- A parent/legal guardian or an authorized adult must deliver medications to the school health room. At the time of delivery, the quantity of each medication will be verified by the school nurse or school personnel. **Please do not send medications to school with your child.**
- Medications given only one time per day or medications that can be given before or after school are not administered at school.
- Prescription medications must be received at school in a container with the original, unaltered prescription label attached. The **label must be written in English and** display all information required by law, including, but not limited to: date of prescription, “discard after date,” student's name, medication name, dosage, time to be administered, and the prescribing healthcare-provider's name.
- Medication may not be administered at school if either the “discard after date” **or** the manufacturer's expiration date has passed.
- Over-the-counter (OTC) and FDA approved non-prescription medications must be in the original sealed (unopened) store-issued container. Please label the container with your child's full name and birth date. OTC medications will only be given according to directions on the label. If a parent/guardian requests dosages that do not appear on the non-prescription medication label, orders stating the reason for the administration variation must be obtained from the healthcare-provider by the parent/guardian and will be considered by a school nurse before administration may occur. **Based on the school nurse's assessment, a parent may be required to obtain a physician's authorization for increased and/or daily administration of a non-prescription medication.**
- If your child is authorized to self-carry and use life saving medications as prescribed by his/her healthcare-provider, the child must demonstrate competency in self-administration/self-treatment and a “Contract for Self-Carried Medication” must also be completed and signed by the parent and school nurse. **Medication with current prescription label must be signed-in to school clinic.**

**Please see reverse side of this document for Medication Authorization**