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| **DISPERSION OF MEDICATION FORM**Escambia County Public Schools Health ServicesJ. E. Hall Center 30 E. Texar Dr. Pensacola, FL 32503 Phone: 850-469-5456 |
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| Please return the completed form to the school health room/office. |
| **I. STUDENT INFORMATION** |
| Student’s Name: | Birth Date | Grade/ Teacher |
| Parent/Guardian  | Address | Allergies |
| Home Phone | Work Phone | Cell Phone |
| **II. ACTION PLAN** |
| THIS REQUEST IS TO BE EFFECTIVE FOR THE SCHOOL YEAR 20 - 20 \_ Diagnosis: NAME OF MEDICATION & STRENGTH (mg, mcg): ROUTE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_LABEL INSTRUCTIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ POSSIBLE SIDE EFFECTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOSAGE (# pills, ml, puffs) TO BE GIVEN AT SCHOOL: \_\_\_\_\_\_\_\_\_\_\_\_\_TIME TO BE GIVEN AT SCHOOL:  |
| **III*.* 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 Short-Acting Bronchodilator s. 1002.20(3)(k), FS Prescribed Pancreatic Enzymes. 1002.20(3)(i), FS Epinephrine Auto-Injector s. 1002.20(3)(j), FS Diabetes Medication and SuppliesThis student is both capable and responsible for carrying and/or self-administering this medication.Print Physician's Name: Address: Physician's Signature: Phone: Date:  |
| **IV. PARENTAL PERMISSION (To Be Completed by Parent/Guardian and witnessed by School District staff or notarized). Form is void if this section is incomplete.** |
| I request the designated school personnel or its agents 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 district, 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 within one week following the above stop date or by the close of the current school year, whichever occurs first. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and school health personnel of the School District of Escambia County and its agents. I assume all risk and liability with respect to my child's use of epinephrine, including any related injection device, inhalant, 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 District Staff Signature: Notary:Signed before me in , Florida this day of 20 . Identification: Known by meSignature of Notary Notary StampPursuant 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 nurse or other designated personnel.9400-HES-005-Revised: May 30, 2024 |