AUTHORIZATION TO DISPENSE MEDICATION

Per chapter 464, Florida Statutes governing the practice of nursing and HRS Manual 150-25a regulating the dispensing of medication in Florida schools, no medication may be dispensed by the medical assistant from the school clinic without permission granted by a licensed physician. Furthermore, such dispensing of medication may not be by general permission only, but the specific medication must also be authorized.

In order for Coral Springs Christian Academy to dispense any medication, including over-the-counter medication, both you and your child's physician must sign this form.

Name of Student _____ Date of Birth: ____/____/_____

Teacher and Grade _____ Date: _____

OVER-THE-COUNTER MEDICATION and PRESCRIPTION MEDICATION

Over-the-counter medication: Doctor, please check which medication(s) may be administered to your patient during school hours:

- ❑ Tylenol _____
- ❑ Ibuprofen _____
- ❑ Benadryl _____
- ❑ Antacid _____
- ❑ Cough Drops/Throat Lozenges _____
- ❑ Other _____

Please give dosage, times, and directions for each medication marked. Please list any possible side effects and/or special instructions.

Prescription medication that is to be administered daily or for an extended period of time:

Diagnosis: _____

Medication(s): _____
Please give dosage, times, and directions on reverse side for each medication.

Please list any possible side effects/and or special instructions on reverse side.
NOTE: Medication must be supplied in the original prescription container. Ask pharmacist to divide the medication into two completely labeled containers, providing one for home and one for school.

_____ _____
Printed Name or Stamp of Physician Physician's Signature

_____ _____
Physician's Phone Number Physician's Fax Number

PARENTAL PERMISSION (Must be completed by Parent or Guardian)

I grant the principal or his/her designee the permission to assist in the administration of all prescriptions, over-the-counter medication, and special procedures to be provided during the school day, including when the above named student is away from school property or on official school business.

Signature of Parent/Guardian: _____ Date: _____

CSCA Clinic Fax Number: 954-346-1112

STUDENT NAME: _____

NOTE TO PHYSICIAN: Please complete the treatment plan for the student named on the reverse side who requires any special health procedures during school hours, e.g., inhaler, nebulizer treatment, glucose testing, etc.

Treatment Plan: _____
_____
_____
_____
_____

Special Procedures (List special procedures in which student has been trained, e.g., insulin administration, use of Epi-pen, nebulizer, testing glucose levels, etc.: _____
_____
_____
_____

Please list any limitations/precautionary measures that should be considered, e.g., physical education, outdoor activities, special devices/equipment: _____
_____
_____
_____

Please state any emergency precautions/health emergencies that should be anticipated for this student, e.g., allergy triggers, diabetic reactions, etc.: _____
_____
_____
_____
_____

What is the care plan for these identified emergencies? _____
_____
_____
_____
_____

Physician's Signature:_____ Date:_____