ACADEMY AT THE LAKES

AUTHORIZATION TO CARRY AND SELF ADMINISTER

Student: _____ Grade: _____ Date of Birth: _____

Parent Name: _____ Parent Phone: _____

PARENT/GUARDIAN PERMISSION:
I request and give permission for my child to be permitted to carry and self-administer the prescribed medication marked below by physician initials per Florida Statute while in school or participating in school sponsored activities. My child has been instructed in and understands the purpose, appropriate method, dosage, frequency and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication. I understand it is my responsibility to ensure that my child has the proper medications, that it is within the expiration date for his/her use, and that the delivery system is functioning properly. My child acknowledges and agrees that the medication is for his/her use alone and that he/she will not share it or otherwise allow it to be used by any other student(s) and that to do otherwise is a violation of the Student Code of Conduct which might subject the student to disciplinary action. My child will immediately notify an employee if another student uses his/her medication or if my child has any questions, concerns, or adverse side effects. I acknowledge that the School Nurse has the authority to revoke the self-administration privilege if there is any irresponsible behavior or safety risk. If my child can self-administer, it is strongly encouraged that a back-up supply of medication is provided to the school clinic.

PARENT/GUARDIAN SIGNATURE: _____ DATE:_____

PHYSICIAN STATEMENT:
The above-named student may carry and/or self-administer the following medication device as outlined below (please mark all boxes that are applicable and initial to the right of all marked boxes):

Metered Dose Inhaler (MDI) ☐ Student may carry ☐ Student may self-administer Initials: _____

Epinephrine for Severe Allergy ☐ Student may carry ☐ Student may self-administer Initials: _____

PHYSICIAN SIGNATURE: _____ DATE:_____

PHYSICIAN NAME (please print): _____ PHONE NUMBER: :_____

REGISTERED NURSE STATEMENT: (to be completed by School Nurse)

I acknowledge that the student named above is authorized to carry and/or self-administer the indicated medication device, and it is my professional judgement that the student can safely and effectively carry and/or self-administer this medication device.

RN SIGNATURE: _____ DATE: _____

A NEW AUTHORIZATION IS REQUIRED EACH SCHOOL YEAR