Authorization for Medication/Treatment

A completed Medication Administration form *MUST* accompany *ALL* student medication. If medication is needed during school hours, **whether it is <u>over-the-counter</u> or prescription,** please send the amount of medication needed, in the original container, along with the completed form below signed by the physician. We will store the medication and arrange for the student to receive the medication as requested between 8 am and 2:30 pm. Also, please note per the Student Handbook, it is school policy that students not carry any medication with them on school property. **Parents/Guardians are responsible for dropping off and picking up medication from the clinic. All medication must be picked up by May 22, 2026.

MEDICATION/TREATMENT CONSENT FORM (<u>ONLY ONE</u> medication or treatment per form)

I request the nurse or designated assistant, to give my child _____

Grade_____ Date of Birth _____ Sex____ Teacher/First Period Teacher _____

<u>To be completed by physician</u>:*(Name of Licensed Provider)* _____

Diagnosis for which the medication or treatment is given: _____

Name of medication or treatment: _____

Dose to be given _____

Time to be given if given at school between 8 am and 2:30PM? _____

What route of administration?(by mouth, inhaler, etc) _____

If medication or treatment is to be given "As needed", please describe indications: _____

_____

How soon can it be repeated? _____ Date to Stop Medication _____

I understand that the provision of Florida Statute 1006.062, school personnel cannot be held liable for reactions or side effects from the administration of the medication(s). I also grant permission for school personnel to contact the physician, APRN, or PA if there are questions or concerns about the medication(s). I hereby authorize SCA's school nurse to reciprocally release verbal, written, faxed or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand Seffner Christian Academy protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed or electronic. I hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this authorization form. I understand that I am responsible to furnish/restock all supplies and medications and that any unused medication that is not retrieved by me at the end of the school year will be destroyed. I hereby release Seffner Christian Academy School Board and its employees from any claims or liabilities connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance.

*****PLEASE NOTE EARLY RELEASE DAYS MAY IMPACT ADMINISTRATION OF MEDICATION.*** Early release time:<u>Wednesday @ 1:30 (meds given until 1pm)</u> Will medication be given? Yes No (Circle)**

Signature of Parent/Guardian _____ Date _____

Signature of Licensed Prescriber _____ Date _____

Printed Name of Prescriber_____ Date _____

<u>Please fax the completed form to the Seffner Christian Academy school clinic at 813-627-0330</u>

MEDICATION REQUEST FORM FOR RESPIRATORY INHALERS

Dear parents/guardian,

For a respiratory inhaler that may need to be administered during the school day, during school-sponsored activities, or while on a school bus or other school property, we must have this form completed by you and by your health care provider. The medication must be supplied by the parent/guardian in its original container from the pharmacy.

Student Name _____Date of Birth_____

Grade_____ Teacher/First Period Teacher_____

Asthmatic: Yes_____ No_____ Other Diagnosis _____

Allergic to_____

Name of Medicine_____

Dose to be given_____

Frequency/time to be given_____

Student requires supervision: Yes___ No ___

Student can carry and self-administer Inhaler Yes_____ No_____

Keep Medication in Nurses' Office ____ Return Medication Home___

Date to stop Medication _____

At the end of the school year, please return my child's medicine by (check one):

_____Sending it home with my child _____Holding all medicine in the clinic to be picked up by parents

(all medicine will need to be picked up no later than 5/26/27)

I give my permission for school personnel to administer prescribed medication listed above. I agree to allow this information to be shared with adults responsible for my child's care. I understand that I am responsible for providing the school with the prescribed Medication in the amount needed and in its original container with label intact as needed by my child. I hereby release Seffner Christian Academy School Board and its employees from any claims or liabilities connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance.

Signature of Parent/Guardian_____ Date_____

Signature of Prescriber _____ Date _____

Printed Name of Prescriber_____

Authorization For Student to Self-Carry and Independently Self-Administer Emergency Medication(s)/Procedure(s) for Life Threatening Medical Conditions

Date: _____

Student's Name: _____ Birth date:_____

Teacher's Name:_____ Grade / Homeroom_____

To be completed by physician:

Diagnosis: _____

The above named student is under my care. This student has a life threatening illness and has been instructed in the proper management of his/her health condition. In addition, this student has demonstrated proper self-administration of medications, treatments and/or procedures and has shown the skill level necessary to manage their own care.

Printed Physician's Name _____ Telephone: _____

Signature: _____ Date: _____

To be completed by parent:

I request for my child to carry and self-administer medications, treatment, and/or procedure, as indicated in the physician's order during the school day, at school-sponsored activities or while in transit to or from school. My child has demonstrated the necessary skill level to implement the care plan prescribed by his/her health care provider. I am responsible for ensuring my child has all medications, treatment, procedure equipment, and supplies for their life threatening health condition. Supervision will not be provided by the school. This form is effective only for this school year and includes all school sponsored activities and summer programs.

By signing this form, I hereby release Seffner Christian Academy School Board and its employees from any claims or liabilities connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance and against any injury or claims that arise as a result of the student's self-management of life threatening health condition. School personnel will contact the child's healthcare provider if there are questions or concerns about the child's healthcare condition and/or treatment. I am aware the privilege of self-administration of medications, treatments, and procedures may be withdrawn if abused by the student. Seffner Christian Academy reserves the right to seek emergency medical treatment for the student when deemed necessary and appropriate.

Telephone: _____ Printed Parent/Guardian Name:_____

Signature: _____ Date: _____

To be completed by student at school:

- ☐ I will keep my medication, supplies & equipment with me at school.
- ☐ I will use only as prescribed by my healthcare provider.
- ☐ I will not allow any other person to use my medication(s) or procedure equipment.
- ☐ I will notify a school staff member if I am having more difficulty than usual with my health condition. Printed Student Name:_____

  Signature: _____ Date: _____