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>