Monroe County School District

AUTHORIZATION TO CARRY MEDICATION(S) PERMITTED BY FLORIDA STATUTE 1002.20:
ASTHMA INHALERS, EPINEPHRINE AUTO-INJECTORS, DIABETES SUPPLIES OR PANCREATIC ENZYMES

Date: _____

Student Name: _____ DOB: _____

School: _____ Grade: _____

It is medically necessary for this student to carry his/her medication and/or supplies while in school and school-related trips as permitted by Florida Statute 1002.20. This student is capable of self-management and administration of the following medication and/or supplies.

This authorization is valid for the current school year only (if for specific dates, please specify).

Medication: ☐ Inhaler ☐ Epi Pen ☐ Insulin / Glucagon ☐ Pancreatic Enzymes

Supplies/Equipment: _____

Dosage/Instructions: _____

_____

Diagnosis: _____

_____	_____	_____	_____
Medical Provider Name	Medical Provider Signature	Phone Number	Date

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I feel my child is capable of self-management and administration of the above medication/supplies.

_____	_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Phone Number	Date

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For Staff Use Only

The student has demonstrated that he/she is responsible in the use and storage of the above medication/supplies.

_____	_____	_____	_____
RN Name	RN Signature	Phone Number	Date