Monroe County School District

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

Date:			
Student Name:	DOB	:	
School:	Grad	e:	
t is medically necessary for this student to rips as permitted by Florida Statute 1002. Collowing medication and/or supplies.	o carry his/her medication and/or suppl 20. This student is capable of self-man	ies while in school and s agement and administrat	chool-related ion of the
This authorization is valid for the curre	nt school year only (if for specific da	tes, please specify).	
Medication: Inhaler Epi Pen	☐ Insulin / Glucagon ☐ Pancre	eatic Enzymes	
Supplies/Equipment:			
Dosage/Instructions:			
Diagnosis:			
Medical Provider Name	Medical Provider Signature	Phone Number	Date
I feel my child is capable of self-managen	nent and administration of the above m	nedication/supplies.	
Parent/Guardian Name	Parent/Guardian Signature	Phone Number	Date
	For Staff Use Only		
The student has demonstrated that he/she	is responsible in the use and storage of	f the above medication/su	upplies.
RN Name	RN Signature	Phone Number	Date