Monroe County School District

Statement of Permission for Administration of Medication Assistance

Student's Name _____ **DOB** _____ **School** _____

In accordance with Florida Statutes and Monroe County School District Policy, this document must be completed and signed before School/Health Staff can assist a student with medication administration.

Conditions for Assistance with Medication Administration

1. School/Health Staff **cannot** assist with the administration of **"over the counter" medication** such as Tylenol, Aspirin, Ibuprofen, Cough Syrup, Antihistamines, Decongestants, etc., *unless* accompanied by a medical provider's written order to include strength dosage, route, scheduling and duration, and is received in a new, unopened container or PREFERABLY LABELED BY A PHARMACIST.

2. School/Health Staff **can** assist a student with the administration of **prescription medication** under the following conditions:

- the prescription medication must be brought to school in it's original container by A PARENT OR GUARDIAN.
- the container must be labeled by a Pharmacist or Physician licensed in the State of Florida.
- the container must include: the student's name
  the medication name, strength, dosage, route, and scheduling,(i.e.: Ritalin 5mg one tablet by mouth at lunch).

3. If the container label reads "take as directed", there **must** be an accompanying dosage, scheduling and duration written and signed by the Medical Provider ordering the medication. Any changes in medication strength, dosage or scheduling after the original container has been received will need to be accompanied by a written or faxed order from the student's Medical Provider.

4. No more than a four week supply of medication may be brought to the school by a parent, legal guardian, guidance counselor, parent educator, other school personnel or Public Health Staff. . **Medication will be counted each time a new container is brought to school. Medication will be kept in original container and secured under lock and key. School/Health Staff will maintain an individual medication record for each student.

5. The individual student medication record is **confidential**. It may be shared only by initialing the line indicating with whom it can be shared:

_____	School Office Staff	_____	Student's Teacher	_____	ESE Team Staff
_____	School Health Staff/Clinic Designees	_____	Student's Medical Provider	_____	Guidance Counselor

6. Medication may be carried by student in original container. ____ yes ____ no Parent initials _____

7. Medication which is no longer prescribed for a student must be picked up by a parent or guardian within five school days. If it is not picked up by a parent or guardian within five school days, the School/Health staff retain the right to properly dispose of the medication.

The undersigned resident of Monroe County, Florida, as parent or legal guardian of _____a student in the Monroe County School District, hereby grants to the Principal or Principal's designee the permission to assist in the administration of each medication provided to the school. It is necessary that the medication be given during school hours. I acknowledge that I have read the above and agree to grant permission for the administration of medication to the above named student under the conditions set forth. I also agree to hold harmless the principal, principal's designee and the Monroe County District School Board for any actions arising from the administration of medication.

_____ _____ _____
Signature Relationship Date

Prescription Pickup or Delivery Receipt for
_____
(Name of Medication & Dosage)

	Amount of Medication		Signatures			Amount of Medication		Signatures	
			Parent	Staff				Parent	Staff
Date	# Received	# Returned			Date	# Received	# Returned		