

THE SCHOOL DISTRICT OF VOLUSIA COUNTY  
HEALTH SERVICES  
**AUTHORIZATION FOR STUDENT ADMINISTERED EPINEPHRINE AUTO-INJECTOR**

NOTE: SCHOOL BOARD POLICY REQUIRES THAT:

1. Prescribed medication can only be self – administered at school when failure to take such medication could jeopardize a student's health.
2. Students may carry an epinephrine auto-injector and self-administer epinephrine by auto-injector when:
  - A. This form is signed by a parent or guardian.
  - B. The doctor who prescribed the medication competes and signs the Doctor's Authorization below.
3. Prescription medication must be brought to school by the student for whom it was prescribed. It must be in the original container labeled by the pharmacy to include the following information:
  - A. **NAME OF STUDENT**
  - B. **NAME OF DOCTOR (licensed and authorized by Florida Law to order prescription medication)**
  - C. **NAME OF MEDICINE**
  - D. **INSTRUCTIONS AS TO DOSAGE**

**\*\*\* PLEASE COMPLETE ALL AREAS \*\*\***

**DOCTOR'S AUTHORIZATION** (To be completed by doctor) **ONLY ONE DRUG PER FORM**

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Student's Name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

The above student is under my medical supervision. I have ordered \_\_\_\_\_

**DOSAGE** \_\_\_\_\_ **EXACT TIME** \_\_\_\_\_ (Name of Medication)

\_\_\_\_\_ at \_\_\_\_\_

\_\_\_\_\_ at \_\_\_\_\_

Reason for medication to be administered at school: \_\_\_\_\_

Possible reactions or side effects: \_\_\_\_\_

**Date this prescription expires:** \_\_\_\_\_

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Doctor's Stamp \_\_\_\_\_ Doctor's Signature \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

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Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PARENT'S STATEMENT**

I request that the above named student be authorized to self-administer the following prescription medication while in attendance at school and school activities. I will assume full responsibility for my child's self-administration and for any side effects and complications my child may have as a result of taking this medication. In addition, I assume full responsibility for any ramification that result from my child's possession of this medication. I understand that it is my obligation to ensure that the medication is not kept beyond its effective date. I agree to indemnify and hold the health department and school board, its employees and assets harmless from any and all liability or damages that may occur due to my child's possession, handling, administration, or lack of safekeeping of said medication.

Signature of Parent/Guardian: \_\_\_\_\_

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Parent/Guardian's Name (Printed) \_\_\_\_\_ Address \_\_\_\_\_

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Home Phone Number \_\_\_\_\_ Emergency Phone Number \_\_\_\_\_ Business Phone \_\_\_\_\_

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School Nurse Supervisor Signature Date