Hillsborough County
PUBLIC SCHOOLS
Excellence in Education

GUIDELINES FOR ADMINISTRATION OF MEDICATION

It is recognized that medications may be essential for some students. When possible, all medications should be administered at home. If medication must be given at school, the following procedures must be followed:

1. A signed statement by the parent/guardian requesting the administration of medication must accompany all medication. The official authorization form (SB 87034) must be returned to school within two (2) days following the initial receipt of the medication. New authorization forms will be required when any changes with the orders occur.

2. Medication must be sent to school via a parent or guardian. It is not safe for children to delivery medicine to the school. This policy prevents safety concerns of lost or stolen medicines, students sharing medicines with friends, students taking medicine unsupervised.

3. Medication must be in the prescription container with the date, dosage, name of drug, and students' and physician's names clearly marked. Medication must remain in the container in which it was originally dispensed. Most pharmacies will provide an extra empty labeled bottle for parents if requested when the prescription is filled.

4. Parents should arrange for a separate supply of medication for school. Medication will not be transported between home and school on a daily or weekly basis. Exceptions by Florida statutes 1002.20(h)(i) are Asthma Inhalers and EpiPens which require special parent forms and physician forms/doctor's orders.

5. When any medications are added or discontinued, a new authorization form will be required.

6. When medication dosages or times are changed, both steps must be followed:

   a) A written note from the parent requesting the changes must be sent to the school and then a new signed authorization form with the correct information must be completed.

   b) A new label from the pharmacist or physician's order/prescription indicating the change must be sent to the school. A fax is acceptable.

7. Medication will be stored in a locked cabinet at the school at all times. Exceptions by statutes are Asthma Inhalers and EpiPens which students carry and require special parent and physician forms/doctor's orders.

8. Since there are a number of students who receive medication during school hours, a school district employee designated by the principal will administer medication.

9. Oral nonprescription (over-the-counter) or sample drugs will be dispensed only when accompanied by written orders from a physician. Medication is always to remain in the container in which it was purchased. Written parental authorization is needed for all nonprescription drugs. Cough drops will be treated as an over-the-counter medication. Students may not carry over the counter medicines at school. Possession of drugs of any kind can lead to serious disciplinary action.

GUIDELINES FOR ADMINISTRATION OF MEDICATION (cont.)

10. Substances not to be given at school are all unregulated products, such as herbs and food supplements, which are being used as treatments, dietary supplements, or folk remedies.

11. *No Prescription Narcotic analgesics* are to be dispensed at school. The side effects make it unsafe for students to attend school while medicated with narcotics.

12. Liquid medication will be given in a calibrated measuring device. The parent should supply a calibrated measuring device.

13. When medication is discontinued or, at the end of the school year, medication not taken home by the parent will be destroyed.

14. Planning and protocols for any medication or treatment which requires one time dosage for a specific intent are the responsibility of the Registered Nurse ONLY>

15. Parents of students attending after school programs, will need to make arrangements with the after-school programs when medicines or treatments are needed.

Florida Statue 1006.062 is the reference for the above guidelines.

Questions regarding these procedures should be directed to the Health Services Nurse assigned to the school your child attends or to the office of School Health Services, Department of Student Support, 273-7020.

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SCHOOL HEALTH SERVICES
PARENTAL AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Date: _____ **Student #** _____

Student's Name: _____ **Date of Birth:**_____
Last First Middle

Teacher's Name: _____ **Grade:**_____ **Room #:**_____

As the parent/guardian of the student named above, we/I request the principal/principal's designee to administer the medication(s) described below to our/my child at school.

Known Allergies

Medication	Amount/ Strength	Dose	Medication Expiration	Time	Purpose of Medication

Date Medication Begins: _____ **Date Medication Ends:**_____

Physician's Name:_____ **Phone Number:**_____

We/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). We/I also grant permission for school personnel to contact the physician if there are questions or concerns about the medication(s). **We/I have read the attached guidelines and agree to abide by them.**

Please list the medications your child takes at home (include dosage and times).

_____
_____
_____

Where does the child go after school?_____

PLEASE NOTE EARLY RELEASE DAYS MAY EFFECT ADMINISTRATION OF MEDICATION.

Early release time:_____ **Will medication be given?** **Yes** **No** **(Circle)**

_____ _____ _____
Parent/Guardian Signature **Home Phone** **Cell/Work Phone**

_____ _____ _____
Parent/Guardian Signature **Home Phone** **Cell/Work Phone**

Distribution: Nurse
SB87034 (Rev. March2017)

Hillsborough County
PUBLIC SCHOOLS
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STUDENT SERVICES/SCHOOL HEALTH SERVICES
EPINEPHRINE AUTO-INJECTORS PHYSICIAN ORDERS

DATE:	**RETURN TO:**
TO:	**SCHOOL:**
ADDRESS:	**ADDRESS:**
NAME:	**Telephone:**
DATE OF BIRTH:	**FAX:**
PARENT/GUARDIAN:	

The student shown above will be attending school in the near future, and we are requiring physician's orders to do the procedures listed below at the school. Please complete the items below and read the statement below. Thank you.

This form is being presented to you to request:

__X__ Physician's orders for medical procedures (*Please specify under response.)*

_____ Medical information: past (_____) current (_____) (An authorization signed by parent is

_____ Exchange information

1. What is the child allergic to? _____
2. What are the signs and symptoms of the student's allergic reaction? _____
3. The ***Epinephrine Auto-injector*** will be kept at the school (√ one) ____ In the clinic. ____ With the student.
4. Is the student aware of this allergy and its possible seriousness? Yes _____ No _____
5. Has the student been instructed in the use of the ***Epinephrine Auto-injector***? Yes _____ No _____
6. Is ***Epinephrine Auto-injector*** to be used immediately? Yes No
   If no, at what time after bite, sting, etc. should it be given? _____
   What are the specific signs that signal the need for epinephrine? _____
7. Is it necessary for the student to carry the ***Epinephrine Auto-injector*** on their person? Yes _____ No _____
8. Will student self-administer? Yes _____ No _____
9. Please list any other specific directions to be followed. _____

Epinephrine Auto-injector is to be administered by School Health Services Nursing Staff and other trained school personnel in the event of a severe allergic reaction.

Physician's Signature: _____ **Date:** _____
Physician's Printed Name: _____
Phone: _____

Distribution: Nurse
SB87033 *(Rev. March 2017)*

Hillsborough County
PUBLIC SCHOOLS
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Authorization For Student to Carry and Independently Self-Administer Emergency Medication(s)/Procedure(s) for Life Threatening Medical Conditions

Date: _____

Student's Name: _____ **Birth date:** _____

School: _____

Teacher's Name: _____ **Grade / Homeroom** _____

To be completed by physician:

Diagnosis: _____

The above named student is under my care. I feel that this student has a life threatening illness and that he/she is capable of and has been instructed in the proper administration of the required medication(s) and/or procedure(s). The student has been instructed in the treatment plan, self-administration of their medications / procedures and has demonstrated the skill level necessary to manage their own care.

Telephone	*Printed Physician's Name*	*Signature*	*Date*

To be completed by parent:

I request and give permission for my child to carry and self-administer the medication(s) and/or procedure(s), as indicated in the physician's order during the school day, at school-sponsored activities or while in transit to or from schools. I have observed my child demonstrate the necessary skill level to implement the care plan prescribed by his/her health care provider. I am responsible for ensuring my child has all medications, procedure equipment and supplies for their life threatening condition. Adult supervision will not be provided. This form is effective only for this school year and includes all school sponsored activities and summer school.

By signing this form, I am indemnifying and holding the district harmless against any injury or claims that arise as a result of the student's self-management of life threatening condition. Permission is also granted for school personnel to contact the physician if there are questions or concerns about the medication(s) and/or procedure(s). We/I are aware the privilege of self-administration of medication(s)/procedure(s) can be withdrawn if abused by the student. The district reserves the right to seek emergency medical treatment for the student when deemed necessary and appropriate.

Telephone	*Printed Parent/Guardian Name*	*Signature*	*Date*

To be completed by student at school:

☐ I will keep my medication, supplies & equipment with me at school ☐ I will use only as prescribed by my doctor ☐ I will not allow any other person to use my medication(s) or procedure equipment ☐ I will notify a school staff member if I am having more difficulty than usual with my health condition.

Printed Student Name	*Signature*	*Date*

Printed Registered Nurse Name	*Signature*	*Date*

Distribution: Nurse

(Updated 10-11-2010) (rev.3.2017)

Allergy-Free Table Participation/Waiver

Student Name: _____ Date: _____

Learning Gate Community School maintains an allergy-free table in our cafeteria. Ths table is available to any child who has no peanuts, tree nuts, or any food product made with those ingredients as part of their lunch. This table is permanently designated by labeling and location in the cafeteria. The table is cleaned with bleach solution which is kept in a color coded container and a separate cleaning cloth designated specifically for this table alone.

_____**I wish for my child to use the allergy-free table during their lunch.**

_____ **I do not wish for my child to use the allergy-free table during their lunch.**

I understand that the school is providing a peanut free, tree nut, and allergy-free table during lunch for the safety of my child. Even though my child has a peanut, tree nut, or other food allergy, I do not feel it is necessary for my child to sit at the allergy-free table. I prefer my child be seated at a regular lunch table and I will notify the school of any changes to my child's allergy status.

Having been made aware of dining options for my child with a food allergy and in electing not to have my child dine at the designated allergy-free table, I will not hold the school responsible for any adverse dietary intake event which may occur as a result of my decision.

Parent Signature: _____ Date:_____

Physician Authorization for Administration of Medication(s)

Student Name_____ DOB__/__/__ Grade/Class_____

Over the counter medication can be given at school with the consent of a parent and **physician's signature is required** for the dispensing of the following common OTC medications. Each medication will be administered as directed by the physician's order (**WITH DOSING AMOUNTS**). Please circle yes of no if your child is allowed to have the medications listed below administered at school.

Acetaminophen for pain **DOSE & Frequency:**	Yes	No	Ibuprofen for pain **DOSE and Frequency:**	Yes	No
Petroleum Jelly for chapped lips, abrasions	Yes	No	Hydrocortisone cream 1% for itching	Yes	No
Heating pad for aches and/or menstrual cramps	Yes	No	Antacid for GI upset (Tums)	Yes	No
Baking soda paste for stings and splinters	Yes	No	Hard Candy for sore throat	Yes	No

Please note If the child has an elevated temperature (≥100.0 ° F), vomiting, diarrhea, rash, green respiratory drainage, green drainage from one or both eyes &/or lice, a parent or guardian will be contacted and will need to make arrangements to pick their child up immediately. Students may not return until they have been fever/symptom free for 24 hours (without medication). If necessary, the school nurse and/or principal may ask for a written statement from a licensed physician stating it is safe for the student to return.

List all allergies, drug reactions, and health conditions:

_____

_____

_____

List all medications taken at home on a regular basis:

_____

_____

_____

We understand that under the provision of Florida Statute 232.46 school personnel cannot be held liable for reactions or side effects from the administration of the above medication(s). We also grant permission to contact myself and/or the physician if there are questions or concerns about medications. I have read the "Guidelines for Administrations of Medication".

Parent/Guardian Signature_____ **Physician Stamp:**

Daytime Contact Number_____

Physician's Signature_____

Physician's Phone Number_____

Date_____