INDIAN TRAILS MUSTANGS
The Big 3!

INDIAN TRAILS MIDDLE SCHOOL

Paul Peacock, Principal
Katherine Crooke Assistant Principal
Ryan Andrews Assistant Principal

5505 N. Belle Terre Parkway Palm Coast, FL 32137
Phone: (386) 446-6732 Fax: (386) 446-7662

THE SCHOOL DISTRICT OF FLAGLER COUNTY
AUTHORIZATION FOR STUDENT TO CARRY AND SELF-ADMINISTER

Epinephrine Auto Injector (EPI-PEN) – Metered Dose Inhaler (MDI) – Insulin Pump – All Diabetic Supplies (including Insulin, Syringes and Glucagon) – Pancreatic Enzymes

**** ONE DRUG PER FORM****

School Board Policy requires that:

1. Prescribed medication can only be administered or self-administered at school when failure to take such medication could jeopardize a student's health.
2. Students may carry or self-administer prescribed medication at school or away from school on official school business when:
   a. This form is signed by a parent or guardian
   b. The physician who prescribes the medication completes and signs the Physician's Authorization below.
3. Prescribed medications must initially be brought to school by the parent/guardian of 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 PHYSICIAN (Licensed and authorized by state law)
   c. NAME OF MEDICATION
   d. INSTRUCTIONS AS TO DOSAGE

An additional supply of medication may be kept at the Nurse's Office.

PARENT'S STATEMENT

Student's Name _____ School _____ Grade _____

I request that the above named student be authorized to carry and self-administer the prescribed Epi-Pen/MDI/Pump while in attendance at school. I will assume full responsibility for my child's self-administration of the issued medication and for any side effects and complications my child may have as a result of taking this medication (including, but not limited to, misuse or abuse) thereby releasing school personnel and the School Board from all liability.

Parent/Guardian Signature _____ Date _____ Home Phone _____

Address _____ Business Phone _____ Cell Phone _____

Physician's Authorization (TO BE COMPLETED BY PHYSICIAN)

The above student is under my medical supervision. I have ordered _____ (Dosage Amount and Frequency)

of _____ (Name of Medication)

POSSIBLE REACTION OR SIDE EFFECTS: _____

REASON FOR MEDICATION TO BE SELF-ADMINISTERED AT SCHOOL: _____

I UNDERSTAND THAT THIS STUDENT WILL CARRY AND SELF-ADMINISTER THIS MEDICATION. Date this order expires: _____

Physician's Phone Number _____ Physician's Signature _____ Date _____

SCHOOL SHOULD RETAIN THIS FORM IN THE SCHOOL NURSE'S OFFICE

School Use: Date Rec'd by Nurse: _____
Date Administration and Teachers of Student Notified by Nurse _____

Updated 9/7/11