



INDIAN TRAILS MIDDLE SCHOOL

Paul Peacock, Principal
 Ryan Andrews, Assistant Principal
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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.

<u>PARENT'S STATEMENT</u>		
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 _____

<u>Physician's Authorization (TO BE COMPLETED BY PHYSICIAN)</u>	
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