DISPERSION OF MEDICATION FORM

THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
J. E. Hall Center 30 E. Texar Dr. Pensacola, FL 32503
Health Services Phone: 469-5456

Please return the completed form to the school health room/office.

I. STUDENT INFORMATION

Student's Name	Birth Date	Grade/Teacher

Parent/Guardian	Address	Allergies

Home Phone	Work Phone	Cell Phone

II. ACTION PLAN

THIS REQUEST IS TO BE EFFECTIVE FOR THE SCHOOL YEAR 20___- 20___ Diagnosis: ____________________

NAME OF MEDICATION/STRENGTH (mg,mcg):______________________________Dosage (# pills, ml, puffs): __________

ROUTE:________________________POSSIBLE SIDE EFFECTS:______________________________

FREQUENCY: ____

______________________________TIME TO BE GIVEN AT SCHOOL:________________________

III. PHYSICIAN PERMISSION (To be completed ONLY if student is to carry and/or self administer medication.)

Florida law only allows students with asthma, life-threatening allergic reactions, diabetes, pancreatic insufficiency or cystic fibrosis, **with parent and physician authorization,** to carry and self-administer the prescribed type of medication as below.

s. 1002.20(3)(h), FS Inhalant
s. 1002.20(3)(i), FS Epinephrine Auto-Injector
s. 1002.20(3)(k), FS Prescribed Pancreatic Enzyme
s. 1002.20(3)(j), FS Diabetes Medication and Supplies

This student is both capable and responsible for ☐ carrying and/or ☐ self-administering this medication.

Print Physician's Name:__________________________________Address: ______________________________

Physician's Signature:______________________________ Phone:________________ Date: __________

IV. PARENTAL PERMISSION (To Be Completed By Parent/Guardian and witnessed by School District staff or notarized). Form is void if this section is incomplete.

I request the designated school personnel or its agents to assist my child in the administration of the above prescribed medication. I give permission for my child to take this medication while in school or while participating in school activities away from the school site. I understand that: (1) there is no liability on the part of the school district, its personnel, or agents, for civil damages as a result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances; (2) this medication must be brought to the school only by a responsible adult; (3) this medication must be in its original labeled container; (4) this medication will be destroyed if it is not picked up within one week following the above stop date or by the close of the current school year, whichever occurs first. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and school health personnel of the School District of Escambia County and it agents. Furthermore, if my child is covered by Medicaid and receives health services under an IEP or any other plan, I consent for the school district to bill Medicaid for those services. I assume all risk and liability with respect to my child's use of epinephrine, including any related injection device, inhalent, insulin, diabetes supplies or prescribed pancreatic enzyme when authorizing my child to self-administer and/or carry the prescribed medication.

Print: Parent/ Guardian Name:______________________________ Date:______________

Parent/Guardian Signature: ______________________________

School District Staff Signature:______________________________

Notary:
Signed before me in__________, Florida this_____day of_________20_____.
Identification:
____Known by me

____
Signature of Notary

Notary Stamp

Pursuant to Section 1006.062, Florida Statute, any student who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated personnel.