

# Florence Christian School

## AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICINE

FAX NUMBER:  
(843)661-4301

2308 S. Irby Street, Florence, SC 29504 (843)662-0454

Top part to be completed by physician. Bottom to be completed by a parent/guardian. Also note the Regulations for Administering Medication to Students are printed on the back. Please return completed form to the school

This form is void if altered in any way.

This request is to be effective for the school year \_\_\_\_\_ or earlier stop date: \_\_\_\_\_

Student's Name: \_\_\_\_\_ DOB or Age: \_\_\_\_\_

Medication: \_\_\_\_\_

Generic Name (If Used): \_\_\_\_\_

Dosage Amount: \_\_\_\_\_ Time to be administered at school: \_\_\_\_\_

Condition for which drug is to be given: \_\_\_\_\_

Note any side effects: \_\_\_\_\_

### INHALANT PRESCRIPTIONS

This student is both capable and responsible for self-administering this medication:

No

Yes-Supervised

Yes – Unsupervised

This student may carry this medication:  No  Yes

Physician/Legal Prescriber's Signature: \_\_\_\_\_

Name(Please Print): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Request: \_\_\_\_\_

I request the designated school personnel to assist my child in the administration of the above prescribed medication. I give permission for my child to take this medication at school. I understand that: (1) there is no liability on the part of Florence Christian School, 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 reasonable prudent person would have acted under the same or similar circumstances; (2) this medication should 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 one week after the close of the current school year, whichever occurs first.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Medication orders must be renewed by the attending physician and release signed by the parent/guardian annually. Each medication, or any change in medication requires a new form.

The parent/guardian will be responsible for ensuring that medicines provided for the school have not expired.

**FLORENCE CHRISTIAN SCHOOL**  
**REGULATIONS FOR ADMINISTERING MEDICATION TO STUDENTS**

Administration of medication is the responsibility of the parent/guardian unless it is absolutely essential to the well being of the student to receive medication during the school day. The following regulations must be observed when medication (prescription or non-prescription) is to be administered in the school:

1. An Authorization for Prescription Medication Administration Form must be on file for each prescribed medication. The form must be completed in its entirety and signed by the physician and the parent/guardian. This form is valid for one school year, or earlier stop date.
2. An Authorization for Non-Prescription Form must be on file for each FDA approved, non-prescription (over-the-counter) medication to be administered at school if taking the medication is necessary for the student to remain at school. The form must be completed in its entirety and signed by the parent/guardian. This form is valid for one school year, or earlier stop date.
3. Medication must be in the original labeled container. A supply of medication provided may be kept at school. For student safety, the parent/guardian or a responsible adult should deliver the medication to the school.
4. The school nurse routinely monitors medication administration and documentation. Questions regarding the purpose, effect, expected results, and side effects of a medication should be referred to the child's physician.
5. Prescription medication must be supplied in the original container labeled by the pharmacist. The prescription label must be consistent with the medication authorization form. The physician's name appearing on the label may be different from the physician's name on the original medication authorization form. No other changes will be allowed.
6. Changes in medication require a new medication authorization form and medication container.
7. Upon receipt, medication will be counted and documented on the Student Medication Record. Medication will be stored under lock and key when not in use.
8. Medication dosage must be age appropriate as stated on the manufacturer's label.
9. Each dose of medication administered will be recorded on the Student Medication Record.
10. In cases where a student is able to medicate himself/herself (according to physician's statement) school personnel will store the medication and generally supervise the student's self-medication. Excluded are students authorized to carry inhalant medication for conditions such as asthma.
11. Medication will be destroyed if not picked up within one week following termination of the medication authorization form or one week after the close of school, whichever comes first. Medication will be destroyed in a manner which it cannot be retrieved (i.e. flushing). Disposal will be witnessed by two persons designated by the principal and documented on the Student Medication Record.

**ALL STUDENT MEDICATION RECORDS WILL BE HANDLED IN A CONFIDENTIAL MANNER**