Return

AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

THIS FORM IS VOID IF ALTERED IN ANY WAY

INSTRUCTIONS: Each of the three sections must be completed by the appropriate person as follows: Parts I and III by Parent/Guardian, Part II by Physician. Please return the completed form to the Head of School.

I. STUDENT INFORMATION (To Be Completed By Parent/Guardian).

Student's Name (Last, First, Middle)	Birth Date	Medicaid #	Grade/Homeroom Teacher

Parent/Guardian	Address

Home Phone	Work Phone	Other Phone (Cellular, WhatsApp, etc.)

II. ACTION PLAN (To Be Completed By Physician). Please complete all spaces.

THIS REQUEST IS TO BE EFFECTIVE FOR THE SCHOOL YEAR 2023-2024 OR EARLIER STOP DATE:_____

CONDITION FOR WHICH DRUG IS TO BE GIVEN:_____

If diagnosis is **ASTHMA**, please check NIH classification of student's asthma severity as follows:

_____ **Intermittent or** _____ **Persistent:** _____ Mild _____ Moderate _____ Severe

NOTE ANY OUTWARD SIDE EFFECTS:_____

FL law only allows students with asthma, life-threatening allergic reactions, pancreatic insufficiency or cystic fibrosis, **with parent and physician authorization,** to carry and self-administer the prescribed type of medication as below. **Circle only ONE that is applicable to the student.**

s.1002.20(3)(h),FS Inhalant
s. 1002.20(3)(i), FS Epinephrine Auto-Injector
s. 1002.20(3), FS Prescribed Pancreatic Enzyme

This student is both capable and responsible for self-administering this medication: No Yes - Supervised Yes - Unsupervised

Print Physician's Name	Physician's Address	Phone

Physician's Signature: Date:

III. PARENTAL PERMISSION (To Be Completed By Parent/Guardian). 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, its personnel, or agents, including Score at the Top, Palm Beach, LLC. personnel, 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 Head of School of Score at the Top, Palm Beach, LLC. I assume all risk and liability with respect to my child's use of epinephrine, including any related injection device, and prescribed pancreatic enzyme when authorizing my child to self-administer and/or carry the prescribed medication.

Parent/Guardian Signature:_____ Date:_____

Pursuant to Section 1006.062, Florida Statute