Medication Authorization Form

If your child requires medication during a Florida Virtual School ("FLVS") in-person event or state testing, Florida Statutes and FLVS Board policies mandates written authorization for all medications. The medication authorization form **must be completed** and **signed by a physician and the parent/legal guardian**. This requirement does not apply to: (1) topical sunscreen product if the product is regulated by the United States Food and Drug Administration for over-the-counter use to limit ultraviolet light-induced skin damage, and (2) medication to relieve headaches if the medication is regulated by the United States Food and Drug Administration for over-the-counter use to treat headaches. Further, this requirement does not apply to in-person events where the student is accompanied by a parent, legal guardian, or adult responsible for the student.

Medications not approved by the FDA, including, but not limited to natural, herbal, homeopathic remedies, food supplements, and vitamins, cannot be administered at school, except for prescribed pancreatic enzymes or dietary products for lactose intolerance. New medications **shall not** be given for the first time during an in-person event or testing.

- Prescribed medication or treatments will be administered at an FLVS Event only if failure to do so would jeopardize the student's health, prevent attendance, if the child is disabled and requires medication to benefit from his/her educational program as may be applicable for the FLVS Event. Medications that can be administered before or after the event should not be given during the event.
- The Medication Authorization Form (attached) must be fully completed, signed by the prescribing physician and the parent/legal guardian. Medications will **not be administered without** a completed Medication Authorization Form. No prescription is needed for FDA approved over-the-counter medications.
- A parent/legal guardian or an authorized adult must deliver medications to the designated person(s) to be responsible for accepting, counting, and administering the medication. The quantity of each medication will be verified upon delivery. The designated person(s) will complete a medication log for each student when medication is administered. Medications will be stored in their original containers under lock and key with the designated staff. Do not send medications with your child.
- Prescription medications must be in the original container with an unaltered label in English, including the prescription date, expiration date, student's name, medication name, dosage, frequency, and prescribing physician's name. Medications past their expiration or "discard after" date will not be administered.
- Over the counter (OTC) and FDA approved non-prescription medications must be in the original sealed (unopened) store-issued container. Please label the container with your child's full name and birth date.
- The child's physician and parent must authorize in writing any self-administration of medication by the student. A student may carry and self-administer a short-acting bronchodilator, epinephrine auto-injector, prescribed pancreatic enzyme supplement and/or may carry diabetic supplies and equipment provided the student's parent or guardian provides the medication authorization form. Medication shall not be carried on a student's person at a FLVS event except as approved by the principal/instructional leader.

Florida Virtual SCHOOL™

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This form **MUST** be completed by a physician (medical doctor) and submitted at least 14 days prior to attending any FLVS in-person event. Only medication in its original container; labeled with the date (if a prescription); student's name; medication name and exact dosage will be administered.

Part to be completed by parent

Student Name: _____ **DOB:** _____ **Student ID:** _____ **Grade:** _____

Parent/Guardian: _____ **Phone:** _____

Other Emergency Contact: _____ **Phone:** _____

Part to be completed by physician

Physician Name: _____ **Phone:** _____ **Date:** _____

Allergies: _____

Diagnosis: _____

Medication	Strength	Dosage	Time to be given	Route	Purpose

It is my professional opinion regarding the self-administration of medication that the:

□ Student is able to self-administer medication.
□ Student is permitted to receive assistance with the administration of medication.
□ Other_____

_____

Physician Signature: **Physician Stamp:**

Part to be completed by parent

Please initial then sign that you have read and understand all the conditions below and on page one of this document.

I certify that I am the parent or guardian of the above-named student, I approve this Medication Authorization form understand that this Medication Authorization form will be shared with necessary Florida Virtual School ("FLVS"), state testing site personnel, county health department, medical personnel, and their employees and volunteers to ensure the safety of the student with a health condition. I authorize the above-medication to be administered as described or prescribed during FLVS in-person events or state testing. With full understanding of the risks involved, on behalf of myself and my child, I hereby release, hold harmless and indemnify FLVS, state testing site personnel, county health department, medical personnel, and their employees and volunteers for damages, payments, fees, and any other monetary obligations and indebtedness of any form caused by or arising from my child's personal injury or death arising from my child's self-administration of medication. I agree that I am responsible for providing the school with my emergency contact information, and my child's Emergency Care Plan (if any), medication, and Medication Authorization form completed by the physician.

____ I understand that medication other than a short-acting bronchodilator, epinephrine auto-injector, prescribed pancreatic enzyme supplement, FDA approved OTC headache medication, and/or diabetic supplies will be held by the contracted medical provider in a locked container during the event.

____ I authorize the above medication to be administered as described or prescribed during FLVS in-person events or state testing.

____ I understand that in case of life-threatening situations, I authorize FLVS staff to contact emergency medical personnel such as 911.

____ By signing this form, I acknowledge that I have read and understand this form in its entirety.

Parent Signature: **Date:**