CITRUS COUNTY SCHOOLS SCHOOL HEALTH SERVICES	STUDENT AUTHORIZATION TO CARRY MEDICATION/SUPPLIES/EQUIPMENT

STUDENT NAME:							
DOB:		AGE:		SCHOOL:		DATE:	

Pursuant to Florida Statute 1002.20, students may carry a metered dose inhaler, epinephrine auto-injectors diabetic supplies and equipment, and pancreatic enzyme supplement. This form must be completed with both parental consent and physician authorization.

Name of Medication:			
Amount to be Given:		Time to be Given:	
Health Condition:			
Allergies:			
Name of Physician:		Phone #:	
Special Instructions:			
What is the necessity for the medication to be provided during the school day?			

This section must be completed by the student's physician.

☐ Metered dose inhaler ☐ Epinephrine auto-injector ☐ Diabetic supplies/equipment ☐ Pancreatic enzyme supplement	This student is capable and responsible for self-administering this medication: ☐ No ☐ Yes This student may carry this medication: ☐ No ☐ Yes

- ALL medication must be properly labeled from the pharmacy, and in the original container.
- A separate form is required for each drug.
- Forms MUST be renewed each school year.
- Any change in the above orders must be in writing from the physician.
- Expired medication or medication not picked up at the end of the school year will be disposed.
- Only the parent or guardian is allowed to sign this form. Medication must be brought to school by an adult.

It is understood by the undersigned that school personnel will not be responsible for the supervision of, the possible misuse of, or any side effects from the administration of the above medication. School personnel may contact the physician if there are concerns about the medication. It is advisable to keep additional medication/supplies/equipment at school with personnel assigned to assist in the administration of medications. **MISUSE OF CARRIED MEDICATION WILL BE SUBJECT TO CONSEQUENCES OUTLINED IN THE STUDENT CODE OF CONDUCT**.

Parent/Guardian Name			Parent/Guardian Signature		
Phone Number:			Date:		
Emergency Names/Numbers:		Name:		Phone Number:	
[redacted]		Name:		Phone Number:	
Physician Signature:			Date:		

(Form shall be maintained as a part of the student's cumulative health record for 1 year from issuing date.) PFCSSC 43 6/96 REV 02/20/14