

MEDICATION RULES

FLORIDA Statutes 1006.062 and the BREVARD COUNTY School Board

Parent Guidelines for Medication Rules – to be given to Parent/Guardian when they fill out parent permission form for medication administration.

1. Parent Permission forms are to be completed for **ALL** medication to be given at school.
2. When completing Parent Permission forms, please make sure that your instructions match the label on the medication container. Clinic staff will not give a medication if the container label has been altered in any way.
3. All medication coming to the school must be in the original container with the manufacturer/pharmacy label in place. This includes all over-the-counter medications.
4. **PLEASE DO NOT ALLOW YOUR CHILD TO TRANSPORT MEDICATION TO AND FROM SCHOOL** – This recommendation is for your legal safety.
5. All medication will be counted upon arrival at school. A second signature will be required to verify a correct count.
6. Over-the-counter medication will remain at school for **10 days** then discarded. If a longer time period is needed then written physicians authorization is required.
7. Clinic staff will administer over-the-counter medication as directed by manufacturer label. Any changes in administration must have written physician's approval.
8. Please do not send loose medication (cough drops, pills, etc.) to school in plastic bags. Clinic staff will be unable to administer these medications to your child.

Effective 8/2011

**PARENT'S REQUEST FOR THE
ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL**

School district policy 5330 **Use of Medications** – states that all medications will be stored properly in the ORIGINAL CONTAINER under lock and key.

FS 1006.062(2) there shall be no liability for civil damages as a result of the administration of such medication when the person administering such medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances.

I hereby grant permission to the principal or his/her designee to assist in administering the following medication to my child.

CHILD'S NAME: _____

DOB: _____ **ALLERGIES:** _____

NAME OF MEDICATION: _____

DOSAGE: _____ **ROUTE:** _____

AT THE FOLLOWING TIME(S): _____ **AM AND/OR** _____ **PM**

EXPLANATION (Why is medication necessary during the school day)

Date

Parent/Guardian Signature

*This form is not to be altered in any way

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