DUVAL COUNTY PUBLIC SCHOOLS
MEDICATION ADMINISTRATION AUTHORIZATION

ONE MEDICATION PER FORM

TO BE FILLED OUT BY HEALTH CARE PROVIDER

Student ____ DOB ___/___/_____ School Year __________________________

Name of Medication ____ Dose_______________ Specific Time _________________

Route by mouth inhaled injection other: _______________________ ICD10 Code ________________________________

Health Condition Requiring Medication ____

Allergies _______________________________________ Known Side Effects ____

Special Instructions ____

I have determined that it is medically necessary for this medication to be provided during the school day for the above named child.
(If you have determined the child needs to self-carry one of the medications listed below, please also sign the bottom section of this form)

____/____/___ ______________________________________ ___________________________ ____________________

Date | Signature of Health Care Provider | Provider Name or Office Stamp

MEDICATION GUIDELINES

A. **Administration of Prescription and Non-Prescription Medication**

1. Whenever possible, medication schedules should be arranged so all medication is given at home.
2. Medication must be delivered to the school by the parent/guardian in the **original prescription or unopened over-the-counter container** and the Medication Administration Authorization form must be signed by the parent/guardian and health care provider (Medical Doctor, Physician Assistant, or Advanced Practice Registered Nurse).
3. Medication Administration Authorization forms must be completed and signed by parent or guardian and health care provider for **each medication** given.
4. A **new** Medication Administration Authorization form is required **each school year** and