MEDICATION/TREATMENT AUTHORIZATION

Instructions: For medical/treatment administration during school hours, read the below requirements.

If your child needs to have medication(s)/treatment(s) given during the school day, state regulations and school board policy require that you and your doctor provide written permission for administration of both prescribed and over-the-counter medication(s) or treatment(s).

Medication refers only to those products which have been approved by the "Food and Drug Administration" (FDA) for use as a drug.

- **Prescribed medications** must arrive in a container with the original, unaltered prescription label attached. **The label must display all legal information required for a pharmacist to dispense a prescription medication such as valid issue and expiration dates, the patient's name, the medication name and dosage instructions, and the doctor's name. The label information must match the physician's order.**

- **Over-the-counter medications** must arrive in the original, unopened store-issued container. Take the time to label the container with your child's full name and birth date, the date you brought the medication to school and the **dosage prescribed by the doctor.**

- The Medication/Treatment Authorization Form on the reverse side of this document must be completed entirely and accompany any medication (either prescribed or over-the-counter) to be given to your child in school. **Both a parent/legal guardian and the prescribing doctor must sign the form.** Staff will not be able to administer medications to your child without this **written consent**.

- The parent, legal guardian, or an authorized adult must hand carry medications to the school health room. The medication brought into the school health room must match the prescribed medication amount. For example, if the prescribed amount is ½ tablet, then it is the responsibility of the pharmacy/parent to cut the tablets. The health room aide upon receipt will verify the quantity of each medication. **Albuterol and Epinephrine Auto-Injectors must be delivered in the original box with the pharmacy label. Do not send medications to school with your child.**

- **The ADMIN at your child's school may need to call the doctor's office for medication/treatment clarification.**

The parent or legal guardian will need to pick up the medication at the end of the school year or if the medication is discontinued or changed during the school year. **If the medication is not picked up, it will be discarded.**

BEYOND THE SPECTRUM
7333 INTERNATIONAL PLACE, SARASOTA, FL 34240 PHONE (941) 907-3443

MEDICATION/TREATMENT AUTHORIZATION

Instructions: Read instructions on page two prior to completing the form.

Student Name ____________________ Sex ____ DOB ____ Grade ____

School ____________________ Student Class ____________ Fax No. ____________

The following section is to be completed by the parent or legal guardian.

I hereby grant permission to the principal or his/her designee of **BEYOND THE SPECTRUM** to assist in the administration of the prescribed medication and/or treatment to my child while in school and away from school while participating in official school activities (F.S.1006.062). **It is my responsibility to notify the school if, and when these orders change**.
I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication and/or treatment where the person administering such medication and/or treatment acts as an ordinarily reasonably prudent person would under the same or similar circumstances.

Parent/Guardian Name ____________________ Relationship ____________

Emergency Phone___ Home Phone ____________ ____________

____
Work Address

List student allergies ____________________

Parent/Guardian Signature ____________________ Date ____________

The following section is to be completed by the prescribing physician. A separate form must be completed for each medication or treatment prescribed. The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following medication/treatment, which is necessary to be given in school. I am aware that trained nonmedical staff may administer this physician prescribed service.

This order is to be effective for the school year: 20____ - 20____ or earlier stop date ______________.

Diagnosis (for this medication/treatment)

Treatment

Name of Medication Brand Generic Strength (i.e. mg/tab)

Instructions to give Amount (i.e. No. of tablets or teaspoons) ____________ Time(s) ____________
Frequency (i.e: every 6 hrs PRN) Duration (i.e: 10 days)

Route ☐ Oral ☐ Topical ☐ Subcutaneous ☐ I.M. ☐ Inhaled ☐ Other (describe)

Time medication is given at home (if applicable)

Possible side effects

Medication expiration date to follow manufacturer's expiration date? ☐ Yes ☐ No

Is student authorized to carry and use asthma inhalation medication or Epinephrine Auto-Injector? ☐ Yes ☐ No

Has student been instructed in the use of asthma inhaler or Epinephrine Auto-Injector? ☐ Yes ☐ No

Is student authorized to carry and self-administer pancreatic enzymes? ☐ Yes ☐ No

Has student been instructed in the use of pancreatic enzymes? ☐ Yes ☐ No

Other Information

Physician Name ____________________

Office Address ____________________ Phone ____________ Fax ____________

Physician Signature ____________________ Date ____________

Medication order reviewed by school RN/LPN ____________________ Date ____________

Medication stopped by Parent/Guardian Signature ____________________ Date ____________

RET: Master, 7Y GW, GS7 158
Dupl., OSA

008-94-HEA
Rev. 4-5-2019

BEYOND THE SPECTRUM OF SARASOTA COUNTY

MEDICATION AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION
MIDDLE SCHOOL AND HIGH SCHOOL STUDENTS ONLY

Instructions: Return this completed form to the Front Desk.

Student Name______________________________ DOB_____________ Sex___________

School: BEYOND THE SPECTRUM

List Child's Allergies ____

I grant permission to the principal or his/her designee to assist in the administration of over-the-counter medication to my child while in school and while participating in field trips. I will supply the named medication in an unopened, original store issued container. I understand that it is my responsibility to hand carry medication to the school health room. **(Do not send medication to school with your child.)** I understand that this agreement is valid until I terminate permission or until the end of the current school year. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances.

Mark only one box below. **(No other medications have been approved.)**

☐ Tylenol or Acetaminophen	(One) 325 mg (regular strength) tablet or 325 mg chewable equivalent every 4 hours as needed (No liquid)

Children must be 12 years of age or older for the medications listed below.

☐ Tylenol or Acetaminophen	(Two) 325 mg (regular strength) tablets or 650 mg chewable equivalent every 4 hours as needed (No liquid)
☐ Tylenol or Acetaminophen	(One) 500 mg (extra-strength) tablet every 4 hours as needed
☐ Advil/Motrin or Ibuprofen	(One) 200 mg (regular strength) tablet or 200 mg chewable equivalent every 6 hours as needed (No liquid)
☐ Advil/Motrin or Ibuprofen	(Two) 200 mg (regular strength) tablets or 400 mg chewable equivalent every 6 hours as needed (No liquid)

Parent/Guardian Name ____

Emergency Phone ______________________________ Home Phone ______________________________

Work Phone ______________________________ Cell Phone ______________________________

Address ____

Street City State Zip

Parent/Guardian Signature ______________________________ Date ______________

____ ______________

Medication Order Reviewed By School ADMIN Name (Print) and Signature Date

BEYOND THE SPECTRUM SARASOTA COUNTY

MEDICATION AUTHORIZATION FOR OVER-THE-COUNTER MEDICATIONS

Instructions: Return this completed form to the Front Desk.

Student Name ____

Date of Birth __________________ Sex ________ School Year 20 _____ - 20 _____ Grade ________

School Name ____

List child's allergies

____

I grant permission to the principal or his/her designee to assist in the administration of over-the-counter medication to my child while in school. I will supply the named medication in an unopened, original store issued container. I understand that it is my responsibility to hand carry medication to the school health room. (**Do not send medication to school with your child.**) I understand that this agreement is valid until I terminate permission or until the end of the current school year. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances.

No other medications have been approved.

☐ Desitin	For use on diaper area: (circle) Rapid relief cream, maximum strength original paste, or multi-purpose ointment
☐ Balmex	For use on diaper area: (circle) Multi-purpose ointment, or diaper rash cream
☐ A and D	For use on diaper area: (circle) Original ointment, or zinc oxide cream
☐ Vaseline	Apply to unbroken skin areas directed by parent
☐ Insect Spray	Apply per package directions

Parent/Guardian Name (Print) ______________________________

Emergency Phone ______________________ Home Phone ______________________

Work Phone ______________________ Cell Phone ______________________

Address ____

Street City State Zip

Parent/Guardian Signature ______________________ Date __________

____ __________

Medication Order Reviewed By ADMIN Name (Print) and Signature Date

Beyond the Spectrum Student Seizure Protocol

Name of Student:________________________________ Date Form completed: ___________

Is the child diagnosed with epilepsy or another seizure disorder?

What does the seizure look like?

When do seizures generally occur?

Are there any known triggers for seizures?

Does the student keep seizure medication at school? Yes No

If yes, does the medication stay at school or go home every night in the student backpack?

What should we do if a seizure lasts one minute or less?

What should we do if a seizure lasts over one minute?

What should we do if a seizure lasts longer than five minutes?

When should we call parents/ guardians?

When should we call 911?

Any other special instructions:

Beyond the Spectrum Student Seizure Protocol Updates

Hello BTS parents and guardians,

Please take a moment to complete in detail your child's seizure protocol. Thank you!

PLEASE RETURN TO SCHOOL AS SOON AS POSSIBLE

Student Name: ____

Parent/ Guardian Signature: ______________________________________