**Beyond the Spectrum**

**Medication Treatment Authorization 2023-2024**

**Revised 06/06/2023**

**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 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 % 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.

Administration 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**

**Medication and Treatment Authorization 2023-2024**

**Revised 06/06/2023**

**Student Name Sex DOB Grade**

**Beyond the Spectrum 941-907-3443 941-527-0526**

**School: Phone and Fax**

**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 because 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer, Address, Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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: 2021-2022 or earlier stop date

|  |  |
| --- | --- |
| Diagnosis and treatment (for this medication) |  |
| Name of Medication (Brand) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Generic) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Strength) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Instructions: Amount\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Route: Oral \_\_\_\_\_ Topical \_\_\_\_\_ Subcutaneous \_\_\_\_\_ IM \_\_\_\_\_ Inhaled \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 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-lniector? Yes | No |
| Has student been instructed in the use of asthma inhaler or Epinephrine Auto-lniector? 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 |
| Physician Name (Print): Signature: |  |
| Office Address/Phone/Fax: |  |
| Medication stopped by Parent/Guardian: Signature: Date: |  |

**Beyond the Spectrum**

**Medication Authorization for Over-the-Counter Medications 2023-2024**

**Revised 06/06/2023**

Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_

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 because 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 only (check one)Rapid relief cream \_\_\_\_\_\_\_\_\_\_Maximum strength original paste \_\_\_\_\_\_\_\_\_\_Multi-purpose ointment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Balmex | For use on diaper area (check one)Multi-purpose ointment \_\_\_\_\_\_\_\_\_\_\_\_\_\_Diaper rash cream \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| A and D  | For use on diaper area (check one)Original ointment \_\_\_\_\_\_\_\_\_Zinc oxide cream \_\_\_\_\_\_\_\_\_\_ |
| Vaseline | Apply to unbroken skin areas as directed by parent |
| Insect Spray | Apply per package direction |

Parent/Guardian Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Beyond the Spectrum**

**Medication Authorization for Over-the Counter Medication**

**Middle and High school Students Only 2023-2024**

**Revised 06/06/2023**

Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_\_\_\_\_

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 chil**d.) 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 because 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 tablet (regular strength)** |
| **Tylenol or Acetaminophen** | **(One) 325 mg chewable equivalent**  |
| **Tylenol or Acetaminophen** | **Every four hours as needed (No Liquid)** |

**Children must be12 years or older for the medication listed below**

|  |  |
| --- | --- |
| **Tylenol or Acetaminophen** | **Two 325mg regular strength tablets OR****Two 650mg chewable equivalent every 4 hours as needed****No Liquid** |
| **Tylenol or Acetaminophen** | **One 500mg extra strength tablet every 4 hours as needed****No Liquid** |
| **Advil/Motrin or Ibuprofen** | **One 200mg regular strength tablet OR****One 200mg chewable equivalent every 6 hours as needed****No Liquid** |
| **Advil/Motrin or Ibuprofen** | **Two 200mg regular strength tablets OR****400mg chewable equivalent every 6 hours as needed****No Liquid** |

Parent/Guardian Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Revised 06/06/2023**

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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 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.

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Administration 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, Florida 34202

941-907-3443

**MEDICATION PICK UP NOTICE**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade: \_\_\_\_\_\_\_\_\_\_\_ School: Beyond the Spectrum

Important information about your child’s medication(s):

School Board policy states “All remaining or unclaimed medication(s) will be discarded unless picked up by a parent or legal guardian.”

Your child’s medication(s) must be picked up on or by the date specified below.

If not picked up on or by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ medication(s) will be discarded.

Medication (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication (2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication (3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication (4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are unable to pick up your child’s medication(s) during school hours of 8:00am to 4:00pm, please call 941-907-3443 to make other arrangements.

School Administration Staff (Print) Date

School Administration Staff (Sign) Date