ST. PAUL LUTHERAN CHURCH & SCHOOL
STUDENT MEDICATION FORM
School Year 2024-2025

This form should be completed only if your child needs to receive a prescription or non-prescription medication at school. **One form per child. This form is to be provided to the School Office**. Information on this form generally will remain within the School Office and may be shared in your child's cumulative file in the school office. Your child's homeroom teacher is authorized to provide a copy of this form to chaperones on school sanctioned school trips.

It is the parent's responsibility to notify the School Office of any change in their child's medical status or medication. For proof of immunization and medical history, **each student must have on file an original physician-completed and signed State of Florida Certification of Immunization record (Form 680). For proof of a physical exam, each child shall have on file an original physician-completed and signed State of Florida Student Health Examination (Form 3040).**

Prescribed medications must be in original pharmaceutical containers and dispensed by the school's office personnel. All medications to be dispensed or administered at School must be supported by an Authorization for Administration of Prescription and Non-Prescription Medication form, signed both by the student's physician and parents. Students are not generally allowed to carry non-prescription or prescription medication while at school. The only exceptions are for Epi-Pens, inhalers, and insulin pens, if supported by a physician order and parental consent and the student is mature enough to be responsible for the appropriate administration. Parents who believe self-administration is appropriate for their child should communicate with the principal.

1. Print clearly child's LAST NAME _____ FIRST _____MI __
DOB ____/____/____ CLASS _____

2. Medications. Circle "H" if taken at home or "S" if taken at school.
H S _____ H S _____
H S _____ H S _____

3. Describe any allergies, chronic or serious illness, medical condition(s), concern(s), or limitation(s)
_____

4. My child wears/has: ____ glasses _____ contact lenses ____ other medical device

5. Contact Information:

MOTHER
Last Name, First _____
Home Phone _____
Work Phone _____
Cell Phone _____
E-mail Address _____

FATHER
Last Name, First _____
Home Phone _____
Work Phone _____
Cell Phone _____
E-mail Address _____

LOCAL EMERGENCY CONTACT 1
Last Name, First _____
Home Phone _____
Work Phone _____
Cell Phone _____
Relationship to Child: _____

LOCAL EMERGENCY CONTACT 2
Last Name, First _____
Home Phone _____
Work Phone _____
Cell Phone _____
Relationship to Child: _____

PRIMARY CARE PHYSICIAN
Name _____
Office Phone _____

___ DENTIST OR ___ OTHER SPECIALIST
Name _____
Office Phone _____

6. My child is covered by the following 24/7 health insurance policy:
_____ (carrier) _____ (policy number)

_____ _____
Parent Signature Date

ST. PAUL LUTHERAN CHURCH & SCHOOL
AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATION
(This form is void if altered in any way)

Instructions: This form only needs to be completed and turned in to the school office if your child needs a prescription or non-prescription medication while at school. Each of the three sections must be completed by the appropriate person as follows: Parts I and III by Parent/Guardian; Part II by Physician. Please return the completed form to the School Office. Your child's homeroom teacher is authorized to provide a copy of this form to chaperones on school sanctioned school trips.

I. Student Information (to be completed by Parent/Guardian)

Print child's LAST NAME _____ FIRST _____MI __ DOB ___/___/___ CLASS _____
Parent/Guardian_____ Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

II. Action Plan (to be completed by Physician). Please complete all spaces.

This request is to be effective for the School Year 20__ - 20__ or earlier stop date: _____
1. Prescription Medication: _____ Generic name (if used): _____
Dosage amount: _____ Time(s) to be administered at School: _____
Condition for which drug is to be given: _____
Note any untoward side effects: _____

Inhalant Prescriptions: This student is both capable and responsible for self-administering this medication:
____ No _____ Yes, if supervised ___ Yes, unsupervised

2. Non-Prescription Medication: _____ Generic Name (if used): _____
Dosage amount: _____ Please administer according to manufacturer's label for recommended time schedule when needed at school for the following conditions or symptoms: _____
_____

3. Non-Prescription Medication: _____ Generic Name (if used): _____
Dosage Amount: _____ Please administer according to manufacturer's label for recommended time schedule when needed at school for the following conditions or symptoms: _____
_____

Print Physician's Name _____ Physician's Address: _____
Physician's Signature: _____ Date: _____

III. Parental Permission (To be completed by Parent/Guardian). Form is void if not completed.

I request the designated school personnel or its agents to assist my child in the administration of the above named prescription and/or non-prescription medications. I give permission for my child to take this medication while in school or while participating in school activities away from the school site. I understand that (1) there is no liability on the part of the school, its personnel, or agents, and hereby release and waive any claims or actions against such persons or entity as the result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances; (2) this mediation must be brought to the school only by a responsible adult; (3) this medication must be in its original labeled container; (4) this medication will be destroyed if it is not picked up within one week following the above stop date or one week after the close of the current school year, or when the medication prescription expires, whichever occurs first. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and school health personnel.

_____ _____
Parent/Guardian Signature **Date** **Parent/Guardian Signature** **Date**

Medication orders must be renewed by the attending physician and release signed by the parent/guardian annually. Each medication or any change in medication requires a new form. The parent/guardian will be responsible for ensuring that medicines provided for the school have not expired or been recalled.