GENERAL MEDICATION PACKET

Here is a helpful checklist...

- ☐ Schedule an appointment with your child's health care provider over the summer to update medications and/or obtain new prescriptions (if needed)
- ☐ Parent: Read and sign the **Medication letter**
- ☐ Parent: Complete the **Medical Release** form
- ☐ Parent: Read and sign the **Medication Authorization** form
- ☐ Parent: Bring completed forms to the clinic along with the medication. Students cannot bring medication to school.
- ☐ Prescription medication must be in the original pharmacy bottle with label attached
- ☐ Over-the-counter medication must be in an unopened bottle

Note: In accordance with OCPS policy, if a student is found with medication or unauthorized inhalers, epi-pens, supplies, etc., the items will be taken and the parent/guardian will need to come to school to pick up the items.

Orange County Public Schools

MEDICAL RELEASE FORM

Dear Healthcare Provider: _____ #_____
Physician Name Phone Number

In order to provide quality health services for: _____,
DOB: _____, at school, it is necessary to obtain a medical history and current medical diagnosis, medications prescribed, physical limitations, nutritional needs and medical orders for care at school. Records received will be placed in the student's health records in the health room accessible to the parent/guardian (or designee), along with designated school personnel.

Please forward all documents to:

Attention: Pam Furman BSN RN

School: Discovery Middle School

Address: 601 Woodbury Rd.

Orlando, FL 32828

Phone: 407-384-1555 ext 5052278 Fax: 407-384-1580

RECORD RELEASE

I hereby give my permission to have any records of my child (health care plans, nursing care plans, immunization history, medical history and current medications) released to my child's school to aid school personnel in serving him/her.

I give my permission for designated school personnel to contact my child's physician regarding current/pending health issues.

Expiration Date: _____. If left blank, this Authorization expires one year from the date signed.

_____ _____
Parent/Guardian Date

_____ _____ _____
Home Phone Number Work Phone Cell Number

Dear Parent/Guardian:

Due to requirements placed on the schools by Florida Statutes Chapter 232.22 (2), the following policy regarding medications dispensed at Discovery Middle School must be enforced.

Periodically, parents/guardians and physicians request that the student take medications during school hours. Parents/guardians are encouraged to develop a schedule so that the necessity for taking medications at school will be minimized or eliminated.

All medications shall be delivered to the Health Room with the following information on the pharmacy container for prescription medications and in the factory sealed container for non-prescription medication:

a. Name and purpose of medication
b. Time the medication is to be given
c. Specific instructions on the administration of the medication
d. Physician name and phone number
e. Pharmacy name and phone number
f. Approximate duration of medication, i.e., end of school year/10 days, etc., and possible side effects are to be listed on the Medication Authorization form.

Parents/guardians **must** bring all medications in the most current labeled container. Parents/ guardians will be required to fill out a Medication Authorization form before medication can be dispensed. **Notes from home will not be accepted as authorization for dispensing medication.** This applies to all prescription as well as non-prescription medication.

If there is no medication authorization form, the medication will not be dispensed. Any medication brought to school without a Medication Authorization form will be held by the School Nurse/Health Room Assistant and the parent contacted. For safety and security reasons, medications must be transported to and from school by the parent/guardian. **Do not send medications to school with the child or siblings.**

Your cooperation in this policy is greatly appreciated. We know that you can appreciate the necessity of such a policy since it deals with the safety of our children receiving medication in our school.

Thank you,

Principal, Jeff Aldridge

Parent Signature

Student Name

Form ID # OCPS1100Stu

Teacher :_____Grade:_____

Authorization for Medications

Prescriptions and Non-Prescriptions

My permission is hereby granted to Discovery Middle School
School

To assist_____ DOB ___/___/____
Last First Middle MM/DD/YYYY

NOTE: If the medication is a prescription, ask your pharmacist to prepare two containers, one for school and one for home. **THE VERY FIRST DOSE OF THIS MEDICATION FOR CURRENT CONDITION/ MAY NOT BE GIVEN AT SCHOOL.** Herbal, vitamin and aspirin (salicylic acid) products require a physician's order.

Name of prescription medication (ex. Ritalin, 20 mg.): _____

Name of prescribing physician: _____

Amount to be given/dosage (ex. 10 mg.): _____

Directions for administering (ex. by mouth): _____

Specific Time to be given at school: _____

Authorization: Beginning Date: _____ Ending Date: _____

Reason or health problem: _____

Possible reaction to medication: _____

OVER-THE-COUNTER MEDICATIONS NEEDED LONGER THAN ONE WEEK MUST HAVE REVIEW AND APPROVAL OF THE SCHOOL NURSE AND MAY REQUIRE A PHYSICIAN'S ORDER. OVER-THE-COUNTER MEDICATIONS NEED TO BE DOSAGE SPECIFIC FOR AGE/WEIGHT. Non-prescription medications will only be accepted in the factory sealed original container. It is hereby understood by the undersigned that school personnel are not held liable for the administration of the above medication or for its possible side effects.

Medication is to be brought in its current labeled pharmacy container. For safety and security reasons, medication must be transported to and from school by the parent/guardian. **DO NOT SEND MEDICATIONS TO SCHOOL WITH THE CHILD/SIBLINGS**. Notes from home will not be accepted as authorization for dispensing medication.

_____ _____/_____/_____
Signature of parent/guardian Date

(___)_____ (___)_____ (___)_____
Home phone Work phone Cell phone / Beeper

Remember to advise the school immediately of changes in the phone numbers, addresses, responsible emergency contact person, doctor, and hospital preference.

Medication Receipt/Pick-up Record

School Year_____

Student Name:_____ School: _____

	Date	Medication	Expiration Date on Prescription Label (if applicable)	Expiration Date on Medication	Amount Received	OCPS Staff Signature	Parent/Guardian Signature
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							

	Date	Medication/Dose Picked -up	Amount picked up	OCPS Staff Signature	Parent/Staff Signature
1.					
2.					
3.					
4.					

Note: Please check all medications for expiration dates: Pharmacy label (if applicable) and the expiration date on the actual medication.