



THE SCHOOL BOARD OF SEMINOLE COUNTY, FLORIDA
AUTHORIZATION FOR OVER-THE-COUNTER
STUDENT SELF-ADMINISTERED MEDICATION

Student Name _____ DOB _____ Grade _____

School _____ School Year _____

My permission is hereby granted for my child to self-administer the following non-prescription medication during school hours and/or school activities.

Students Grade KG-5 May carry and self-administer:

Non-Aerosolized Sunscreen Non-Medicated Lip Balm Non-Aerosolized Insect Repellent

Students Grade 6-12 May carry and self-administer:

Name of medication: _____

- Each OTC medication requires a separate authorization form.
- All medication must be in the original container and clearly labeled with student's name.
- The amount of medication carried by the student should not exceed the daily dosage as recommended on the container label.
- Medication must be administered in accordance with the instructions on the container label.

I request that my child _____ be permitted to carry the above medication on his/her person, as I consider him/her responsible.

- My child has been instructed in and understands the purpose, appropriate method, frequency, and use of his/her medication.
- My child understands that he/she is responsible and accountable for carrying and using his/her medication.
- My child acknowledges and agrees that the medication is for his/her use alone and that he/she will not share it or otherwise allow it to be used by any other student(s) and that to do otherwise is a violation of the Student Code of Conduct which might subject the student to disciplinary action.
- My child will immediately notify an employee of The School Board of Seminole County, Florida if another student uses his/her medication.
- It is understood that if there is irresponsible behavior or a safety risk, the privilege of carrying his/her medication will be rescinded.
- I understand and acknowledge that The School Board of Seminole County, Florida assumes no responsibility whatsoever for the maintenance, storage, dosage, replacement if damaged or lost or administration of the above student's self-administered OTC medication.
- I furthermore agree to indemnify and otherwise hold harmless The School Board of Seminole County, Florida, its employees, and volunteers for any and all liability with respect to the student's use or misuse of such medication pursuant to s.1002.20(3)(p).
- I understand that a copy of this form must be turned into the school clinic and a copy should be carried by the student with the medication.

Print Name of Parent/Legal Guardian _____ Date _____

Signature of Parent/Legal Guardian _____ Relationship _____

***** DISTRICT USE ONLY *****			
Reviewed by School Board Nurse:		Date:	