EAST HILL CHRISTIAN SCHOOL
PH: 850.438.7746 FX: 850.434.7384
1301 E. Gonzalez St. Pensacola, FL 32501
www.ehcs.org

DISPERSION OF MEDICATION FORM

INSTRUCTIONS: Please return the completed form to the Front Office.

I. STUDENT INFORMATION (To be completed by Parent/Guardian).

Student's Name (Last, First, Middle)	Birth Date	Grade	Allergies

Parent/Guardian	Address

Home Phone	Work Phone	Cell Phone

II. ACTION PLAN (To be completed by Parent/Guardian).

This request is to be effective for the school year 20___ - 20___ Diagnosis: _____

Name of Medication/Strength (mg, mcg): _____ Dosage (# pills, ml, puffs): _____

Route: _____ Possible Side Effects: _____

Frequency: _____ Time to be given at school: _____

III. PHYSICIAN PERMISSION (To be completed ONLY if student is to carry and/or self administer medication.)

Florida law only allows students with asthma, life-threatening allergic reactions, diabetes, pancreatic insufficiency or cystic fibrosis, **with parent and physician authorization**, to carry and self-administer the prescribed type of medication as below.

- s. 1002.20(3)(h), FS Inhalant
- s. 1002.20(3)(i), FS Epinephrine Auto-Injector
- s. 1002.20(3)(k), FS Prescribed Pancreatic Enzyme
- s. 1002.20(3)(j), FS Diabetes Medication and Supplies

This student is both capable and responsible for ☐ carrying and/or ☐ self-administering this medication.

Print Physician's Name: _____ Address: _____

Physician's Signature: _____ Phone: _____ Date: _____

IV. PARENTAL PERMISSION (To be completed by Parent/Guardian and witnessed by the Front Office staff or notarized). Form is void if this section is incomplete.

I request the designated school personnel to assist my child in the administration of the above prescribed medication. 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 East Hill Christian School, its personnel, or agents, for civil damages as a 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 medication 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 by the close of the current school year, whichever occurs first. I hearby authorize the exchange of medication information regarding my child's treatment plan between the physician and the EHCS Front Office. I assume all risk and liability with respect to my child's use of epinephrine, including any related injection device, inhalant, insulin, diabetes supplies or prescribed pancreatic enzyme when authorizing my child to self-administer and/or carry the prescribed medication.

Print Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____

EHCS Staff Signature: _____

Notary:
Signed before me in _____, Florida this _____ day of _____ 20____.
Identification:
____ Known by me

_____
Signature of Notary Notary Stamp

Pursuant to Section 1006.062, Florida Statute, any student who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated personnel.

Information from The School District of Escambia County Health Services 9400-HES-005-A; Revised June 7, 2017