3221 Sand Lake Rd, Longwood, FL 32779 | Phone: (407) 869-8882 | Fax: (407) 637-5309 l www. pacebrantley.org

Dear Parent/Guardian,

Due to requirements placed on the schools by Florida Statutes Chapter 232.46, also implementing Seminole County Health Services, 5.62 the following policy regarding medications dispensed at PACE Brantley School must be enforced.

Periodically, 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 labeled pharmacy container for prescription medications and in the factory sealed container for non-prescription medications:

a) Name and purpose of medication
b) Time the medication is to be given
c) Specific instructions on the administration of the medication
d) Approximate duration of medication i.e. end of school year/IO days etc.
e) 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 signed by the doctor 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, such as Advil or Tylenol medications. Parents/Guardians must sign controlled prescription medication in with the nurse.

IF THERE IS NO MEDICATION AUTHORIZATION FORM, THE MEDICATION WILL NOT BE DISPENSED. Any medication brought to school by a student without a Medication Authorization Form will be held by the Health Room Assistant/School Nurse and the parent/guardian contacted. 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 OR SIBLINGS.

Your cooperation in this policy is greatly appreciated. We know that you can appreciate the necessity of such a policy. Thank you for helping us provide a safe and healthful school environment for your children.

Sincerely,

Tara Mahoney

Tara Mahoney, NASN # 114322, BA-RN, LPN
School Nurse

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Over the Counter

Dear Parent,

Please check below the OVER THE COUNTER medications you allow the School Nurse to administer to your student.

_____Caladryl Clear (relives itching and pain from insect bites/minor skin irritations)

_____Betadine Solution (topical antiseptic for cuts/scrapes)

_____Bacitracin/Neomycin/Polymyxin Ointment (antibiotic ointment for minor cuts/scrapes)

_____Neosporin Antibiotic Ointment (for minor cuts and scrapes)

_____Chlorseptic Throat Lozenges (for sore throat)

_____Halls Cough Drops

_____Foille Medicated First Aid Spray (for minor cuts/scrapes/sunburn pain)

_____Campho-phenique Antiseptic Liquid (for insect bites/scrapes)

_____Orasol (anesthetic/antiseptic for mouth and gums)

_____Visine (eye drops)

_____Tums (antacid for indigestion/heartburn)

By signing below, you authorize the School Nurse to administer OVER THE COUNTER medications to your student.

Parent Signature _____Date_____

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Health History

Student Name _____Date of Birth _____Grade_____

Please describe any current/existing health issues your child has (including medical, developmental and psychological concerns and diagnoses) _____

_____

_____

Please describe any previous health issues your child has had (include hospitalizations, surgeries and illnesses lasting more than one week)_____

_____

_____

Is your child under the care of a physician? No _____ Yes ____ If yes, please explain: _____

_____

_____

Is your child currently taking medication? No _ _____ Yes ___ If yes, please list ALL medications. Dosage and Time of day medication is taken

MEDICATION _____ DOSAGE _____ TIME TAKEN_____

MEDICATION _____ DOSAGE _____ TIME TAKEN_____

MEDICATION _____DOSAGE _____ TIME TAKEN_____

Does your child experience allergies? No ____ Yes ____ If yes, please explain: _____

_____

_____

Has your child fractured or broken a bone? No ____ Yes ____ If yes, please explain: _____

_____

_____

Do you know of any reason why your child should NOT participate in PE sports and activities? No _ Yes ____ If yes, please explain: _____

_____

_____

Does your child wear contacts or glasses? No _____ Yes ___

Do you have additional concerns we should be aware of? No _ Yes ____ If yes, please explain: _____

_____

_____

Contact Information: Home Phone _____

Mom's Cell _____ Mom's Work _____ Mom's Email _____

Dad's Cell _____Dad's Work _____ Dad's Email _____

_____

Parent Name Parent Signature

Pace Brantley School is a non-denominational school that admits students of any race, color and national or ethnic origin. PBS is a non-profit 501©3 organization accredited by FCIS. Tax Exempt ID # 59-1501677

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Student Medication Authorization (1 of 2)

Student Name _____

Date of Birth _____ Grade_____ Sex: Male _____ Female ____

Address _____
Street City State Zip Code

The following section is to be completed by the prescribing physician prior to the administration of medications. The following medication(s) is necessary to be given in school and during school sponsored activities, I am aware that this medication may be administered by non-medical personnel.

Diagnosis for which medication will be required in school:

Medication: _____ Strength: _____ Dosage: _____

Route: Oral _____ Topical _____ Inhaled _____ Other (please describe) _____

Frequency:
If medication is to be given at a *schedule time*, what time? _____

If medication is to be given *when needed*, when would it be indicated? _____
--How many times can it be given? _____
--How soon can it be repeated after each dose? _____

Length of time (duration) medication is ordered: _____

If applicable, is the student authorized to carry and self-administer medication? Yes ____ No ____

Is middle or high school student authorized to self-administer OVER THE COUNTER medication? Yes__No__

List any significant side effect to the medication: _____

_____
Physician's Name, Address and Phone

_____
Physician's Signature Date

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Student Medication Authorization (2of 2)

The following section is to be completed by the parent/guardian:

I hereby grant permission to Pace Brantley School and it's designees to assist in the administration of the above prescribed medication to my child while in school and during school sponsored activities (FS232.46), (SC5.62). It is my responsibility to provide the school with a new medication authorization form if and when these orders change. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication act as an ordinarily prudent person would under the same or similar circumstances.

_____

Parent/Legal Guardian Name Parent/Legal Guardian Signature
Date

_____

Parent Best Contact Number

_____

Parent Email

NOTE:
All prescribed medication to be administered at school must be received in the original containers
This authorization is valid for 12 months only and must be renewed each school year.