ST. JOHNS COUNTY SCHOOL DISTRICT

HEALTH SERVICES

PARENT PERMISSION FOR STUDENT TO USE NON-PRESCRIPTION MEDICATION TO TREAT HEADACHES

School: _____

Request Beginning (Date): _____To: _____
(not to exceed one (1) school year)

Student: _____ Student #: _____ Date of Birth: _____

Student Allergies: _____

Parent/Guardian: _____ Contact: _____
PLEASE PRINT

Second Contact Person: _____ Contact: _____
PLEASE PRINT

Florida Statute 1002.20 allows students to possess and use a medication to relieve headaches while on school property or at a school-sponsored event or activity if the medication is FDA approved for over-the-counter use to treat headaches.

Products MUST remain in the original container and be labeled with the student first and last name. Students may NOT share the product with any other persons.

This form must be completed, including signature, and provided to the school clinic prior to student possessing medication at school.

Possession/Use of Non-Prescription Medication for Headache

Name of Headache Medication: _____ Expiration Date:_____

Dosage (strength): _____ Amount to be Given:_____

Route of Administration: _____ How often can Medication be Administered: _____

Please choose one option and sign/date:

AUTHORIZATION FOR NURSE TO ASSIST	AUTHORIZATION TO POSSESS AND SELF-ADMINISTER
I hereby authorize for the FDA approved, over the counter products(s) indicated above to treat headaches, be held in the clinic and request that the nurse or principal's designee assist in the administration of this medication for my above named student. I release the School District from liability in connection with assisting with the administration of the product. Parent/Guardian Signature: _____ Date: _____	I hereby authorize my above named student to possess and self-administer the FDA approved, over the counter product(s) indicated above to treat headaches. I have discussed the indication and use of the product(s) with my student. Additionally, my student understands they may not share their product(s). I understand that if there is inappropriate behavior or a safety risk, the privilege of carrying his/her medication will be rescinded. I release the School District from liability in connection with the possession and use of the product(s). Parent/Guardian Signature: _____ Date:_____