PERSONAL | PASSIONATE PROGRESSIVE

Authorization to Carry and Self Administer Over-the-Counter Headache Medication
The School District of Lee County

School Year 20_____ - 20_____

Student Name: _____ Student ID: _____ DOB: _____

Parent/Guardian Name: _____ Phone: _____

Name of Medication: _____

Pursuant to Florida Statute 1002.20(3)(p) – A student may possess and use a medication to relieve headaches while on school property or at a school-sponsored event or activity without a physician's note or prescription if the medication is regulated by the United States Food and Drug Administration for over-the-counter use to treat headaches.

In order for your child to carry and administer his/her own over-the-counter medication to relieve headaches this document must be fully completed annually and on file in the school clinic or your child will not be permitted to carry or administer his/her own medication. Your child must be able to answer the questions in Part B or he/she will not be permitted to carry or administer his/her own medication to relieve headaches. This is for the safety of your child and others.

A. To be completed by the Parent/Guardian:

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 District of Lee County 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that if there is irresponsible behavior or a safety risk, the privilege of carrying his/her medication will be rescinded.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 District of Lee County assumes no responsibility whatsoever for the maintenance, storage, dosage, replacement if damaged or lost or administration of the above student's medication. I furthermore agree to indemnify and otherwise hold harmless The School District of Lee County, 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).

Parent/Guardian Signature: _____ Date: _____

B. To be completed by the Student:

____ Student knows the name, purpose, and correct use/administration of the medication.
____ Student understands and agrees that it is his/her responsibility to carry/administer his/her own medication.
____ Student understands and agrees that allowing anyone else to use this medication will result in disciplinary action.

Student Signature: _____ Date: _____