THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

Coordinated Student Health Services, 1400 NW 14 Court, Fort Lauderdale, FL 33311

AUTHORIZATION FOR MEDICATION: Prescription or Over-the-Counter Medication

Student's Name: _____Date of Birth: _____Grade: _____
School: _____Phone #: _____Fax#: _____

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Allergies: _____
Diagnosis: _____

MEDICATION	DOSAGE & ROUTE	FREQUENCY	SPECIFIC TIMES	SPECIAL INSTRUCTIONS/ SIDE EFFECTS

List any emergency precautions / health emergencies that should be anticipated for this student; e.g. allergy triggers, diabetic reactions, etc.) : _____

_____

There are no extraordinary emergency medical services available at school. Since only CPR and first aid are available until 911 arrive, is this adequate for student survival? ☐ YES ☐ NO, IF **"NO",** specifies:

_____

****

_____ _____
Physician's Name (Printed) **Physician's Signature**

_____ _____
Physician's Telephone & Fax Numbers

_____ _____
Physician's Office Address **Date Completed**

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This information will be obtained by School Board District Personnel

PARENTAL PERMISSION FOR MEDICATION

(TO BE COMPLETED BY THE STUDENT'S PARENT / GUARDIAN)

Student's Name: _____Date of Birth: _____Grade: _____

I grant the principal or his / her designee the permission to assist or perform the administration of each medication to or for my child during the school day, including when he/she is away from school property for official school events. If my child has been authorized by his/her physician to self-administer their medication(s), I grant permission for my child to self-administer their medication at school and when they are away from school property for official school events. In the event that my child is unable to self-administer their medication, I give permission for the principal/designee to perform the administration of the prescribed medication.

NOTE:

- **Medications must be supplied in the original container.** Ask the pharmacist to divide the medication into two completely labeled containers, providing one for home and one for school.
- School personnel may administer only medications authorized by a physician.
- It is your responsibility to notify the school when there is a change in medication regimen.

_____ _____
Parent / Guardian Name (Printed) Signature of Parent / Guardian

_____ _____
Date Signed Home Phone Number

_____
Work/Cell Phone Number (Include Ext. if any)

Form #2240 Rev. 8/15

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

Coordinated Student Health Services, 1400 NW 14 Court, Fort Lauderdale, FL 33311

AUTHORIZATION FOR TREATMENT

Student's Name: _____Date of Birth: _____Grade: _____
School: _____Phone #: _____Fax#: _____

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Diagnosis: _____ Allergies: _____

TREATMENTS DURING SCHOOL HOURS

Treatment Plan: _____

PROCEDURE	TYPE	MEDS / FEEDING AMOUNT	FREQUENCY SPECIFIC TIMES	RATE / FLOW
Catheterization				
Feedings	☐ G-Tube ☐ J-Tube ☐ NG-Tube ☐Special _____			
Suctioning	☐ Oropharynx			
	☐ Tracheostomy ☐ Deep ☐ Surface			
Tracheostomy	☐ Tube Replacement			
	☐ Care (Cleaning)			
CPT				
Oxygen /Misting				
Ventilator				
Nebulizer Tx				
Pulse Oximeter				

Are any of the above procedures required for emergency care? ☐ YES ☐ NO, IF **"YES",** specify: _____

List any procedures the student has been trained to perform _____

List any limitations / precautionary measures that should be considered; e.g. physical education, outdoor activities, transporting, lifting, moving, special devices / equipment: _____

_____

List any emergency precautions / health emergencies that should be anticipated for this student; e.g. allergy triggers, diabetic reactions, etc.) : _____

_____

There are no extraordinary emergency medical services available at school. Since only CPR and first aid are available until 911 arrive, is this adequate for student survival? ☐ YES ☐ NO, **IF "NO", specifies**: _____

_____ _____
Physician's Name (Printed) **Physician's Signature**

_____ _____
Physician's Telephone & Fax Numbers

_____ _____
Physician's Office Address **Date Completed**

****

This information will be obtained by School Board District Personnel

PARENTAL PERMISSION FOR TREATMENT

(TO BE COMPLETED BY THE STUDENT'S PARENT / GUARDIAN)

Student's Name: _____Date of Birth: _____Grade: _____

I grant the principal or his / her designee the permission to assist or perform the administration of each treatment/procedure to or for my child during the school day, including when he/she is away from school property for official school events. If my child has been authorized by his/her physician to self-administer their medication(s), I grant permission for my child to self-administer their treatment at school and when they are away from school property for official school events. In the event that my child is unable to self-administer their treatment, I give permission for the principal/designee to perform the administration of the prescribed treatment. **NOTE: school personnel may administer only treatments authorized by a physician.** ***It is your responsibility to notify the school when there is a change in treatment regimen***.

_____ _____
Parent / Guardian Name (Printed) Signature of Parent / Guardian

_____ _____ _____
Date Signed Home Phone Number Work/Cell Phone Number (Include Ext. if any)