Authorization for Treatment Form 2017/2018 (All Grades)

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

Coordinated Student Health Services • 1400 NW 14th Court, Ft. Lauderdale, FL 33311 • (754) 321-1575

Authorization for Treatment

(THIS SECTION IS TO BE COMPLETED BY THE ATTENDING PHYSICIAN ONLY)

Student Name _____ Date of Birth _____ Grade _____

School _____ Phone # _____ Fax # _____

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): _____

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

Physician's Name (Print) _____ Physician's Signature _____

Physician's Office Address _____

Physician's Telephone # _____ Physician's Fax # _____

Date Completed _____

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This information will be obtained by School Board District Personnel

PARENTAL PERMISSION FOR MEDICATION

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

Student 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 (Print) _____ Parent/Guardian Signature _____

Date Signed _____ Home Phone # _____ Work/Cell Phone # _____
(include Ext. if any)