THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
Health Education Services, 600 SE 3 Avenue, 12th Floor, Ft. Lauderdale, FL. 33301 Phone: 754-321-2272 Fax: 754-321-2743

AUTHORIZATION FOR MEDICATION / TREATMENT

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

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				
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 : _____

_____

_____

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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 arrives, is this adequate for student survival? ☐ YES ☐ NO, **IF "NO",** specify:
____
____
____

______________________________	______________________________
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 / TREATMENT

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

Student's Name: ______________________ **Date of Birth:** _____________ **Grade:** ______________
School: ______________________________ **Phone #:** _________________ **Fax#:** ________________

I grant the principal or his / her designee the permission to assist or perform the administration of each medication or 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 medication/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 medication, I give permission for the principal/designee to perform the administration of the prescribed medication or treatment.

NOTE:

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

______________________________	______________________________
Parent / Guardian Name (Printed)	Signature of Parent / Guardian
______________________________	
Date Signed	
______________________________	______________________________
Home Phone Number	Work Phone Number (Include Ext. if any)

____
Other numbers where you may be reached during school hours (Include cellular phone and beeper)

Form: #2240E
Revised: 5/10