# THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

Coordinated Student Health Services *(formerly Health Education Services)*, 600 SE 3 Avenue, 9th Floor, Ft. Lauderdale, FL. 33301
Phone: 754-321-2272

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

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

***********************************************************************************************************

**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 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**

***********************************************************************************************************

**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.
- Only medications 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 regimen.

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

______________________________ ______________________________
Date Signed Home Phone Number

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

# THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

Coordinated Student Health Services, 600 SE 3 Ave, 9th Floor, Ft. Lauderdale, FL. 33301 Phone: 754-321-2272

## AUTHORIZATION FOR TREATMENT

**Student's 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<br>☐ NG-Tube ☐Special _______ | | | |
| Suctioning | ☐ Oropharynx | | | |
| | ☐ Tracheostomy ☐ Deep<br>☐ 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 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**

************************************************************

**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:** ***Only 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 treatment regimen.***

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

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