THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
1400 NW 14th Ct. Bldg 17 • Fort Lauderdale, Florida 33301 • 754-321-1575

Coordinated Students Health Services
Marcia Bynoe, ARNP-BC, MSN, FNP/SNP, Director
www.browarschools.com
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Dear Parent,

The following information is to assist you, as the parent/guardian, with providing health information required for your child by Broward County Public Schools. If you should have any questions, please feel free to contact your school.

Medical Examination
All students entering Broward County Public Schools for the first time must have a medical examination performed within one year of registration. The medical examination should be documented on the Florida Department of Health Form 3040 or on the provider's office/medical facility stationery. The appropriate form/stationary should be completed, signed and dated by the healthcare provider.

Communicable Diseases/Illnesses
Please inform the school if your child is out sick with a diagnosed communicable illness such as meningitis, measles, salmonella, etc.

Please keep your child home if your child has:
- Flu-like symptoms
- Fever greater than 100.4 degrees
- Sore throat, coughs, chills, and/or body aches
- Rashes, yellow eye drainage, or greenish-yellow phlegm from a cough or cold, vomiting, diarrhea, etc.

Chronic Health Conditions
If your child has any of the following health conditions, including, but not limited to, asthma, diabetes, cystic fibrosis, sickle cell anemia, seizures, allergic reactions to food, insect bites, etc., please inform the school.

Parents should:
- Document the chronic health condition on the Student Emergency Contact Card and complete the history on the back of the card.
- Meet with school administration to discuss care of the student while at school
- If the student is on medication, provide the school with a current Medication Authorization form signed by the healthcare provider and parent

Note: A Diabetes Medication/Treatment Authorization form must be completed by the healthcare provider and parent for students with diabetes. Students who received insulin via an insulin pump must also complete an Insulin Pump Medication/Treatment Authorization form.

Medication Administration at School (Prescription or Over-the-Counter)

- If your child needs to take over-the-counter (OTC) or prescribed medication at school or on a field trip, an Authorization for Medication/Treatment form must be completed and signed by the healthcare provider and parent
- **Parents** must transport/deliver **ALL** medications to school staff in the original, labeled container (unless your child is authorized to carry their medication per the Authorization for Medication/Treatment form)

Authorization for Selected Over-the-Counter Medication (OTC) with Parental Approval Grades 9-12 Only

- If your child needs to take over-the-counter (OTC) medication at school or on a field trip, an Authorization for Selected Over-the-Counter Medication (OTC) with Parental Approval Only form must be completed and signed by the parent/guardian, student and be notarized
- Self-carry, self-administration of the selected over-the-counter medications only:
  - Tylenol
  - Motrin
  - Allegra
  - Claritin
  - Tums
  - Lactaid
  - Midol

Authorization for Over-the-Counter (OTC) Topical Products with Parental Approval Only

- Students in all grade levels are permitted to self-carry and self-administer bug, insect, mosquito repellent (wipes, towelettes or lotions only) and sunscreen (no aerosol products permitted.
- An Authorization for Over-the-Counter (OTC) Topical Products with Parental Approval Only form must be completed and signed by the parent/guardian

Note: Plan ahead for field trips if your child needs medication for an overnight trip that he/she may not normally take at school. Update changes to your child's health condition as they occur.

Immunizations (Please refer to F.S. 1003.22)

- Make sure your child's required immunizations are up to date. If you are not sure, you can check with your healthcare provider or the Florida Department of Health-Broward at (954) 467-4700
- Parents may obtain medical exemptions from their healthcare provider or a religious exemption from the Florida Department of Health-Broward

School Health Centers, Community Resources, Immunizations & Health Care

- Information is available on Broward County Public Schools website at http://www.browardhealthservices.com/resources/
- If you do not have insurance, you can request an application for Florida KidCare Insurance at your child's school

Florida Heiken Children's Vision Program

- The Florida Heiken Children's Vision Program provides vision examinations and eyeglasses when prescribed, to students in need of comprehensive vision services at no cost to the student.
- Eligible students for the program must meet the criteria of the Free and Reduced Lunch Program and have failed the vision screening
- The Florida Children's Vision Program consent form will be sent home during the first week of school for parent/guardian signature
- If your child meets the above criteria and you would like your child to participate in the program, please complete, sign and return the consent form to the school

Additional information on school entry requirements is available at http://www.browardhealthservices.com/parent-information/registration-requirements/.

If you have any questions, please contact your child's school.

Authorization for Medication Form (All Grades)

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

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

Prescription or Over-the-Counter Medication

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

Student 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): _____

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 _____

****

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 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:

- **Medication 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 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 (Print) _____ Parent/Guardian Signature _____

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

Authorization for Treatment Form (All Grades)

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

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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 _____

****

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)

Authorization for Selected Over-the-Counter (OTC) Medication with Parental Approval (Grades 9-12)

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Authorization for Selected Over-The-Counter (OTC) Medication with Parental Approval Form (Grades 9-12)

Instruction: Each section must be completed by parent/guardian for student to self-carry or self-administer any of the listed Over-the-Counter (OTC) medication with parental approval only. The form is void if any section is incomplete. This form is to be signed by the parent/guardian, student and notarized.

Instructions: Each section must be completed by parent/guardian for student to self-carry or self-administer any of the selected over-the-counter (OTC) medication with parental approval only. The form is void if any section is incomplete. This form is to be signed by the parent/guardian, student and notarized.

I. Student/Parent Information

Student's Name (Print Name)	Birth Date:	Allergies	Grade:
Parent/Guardian (Print Name)		Address:	
Home Phone:	Work Phone:	Other Phone:	
II. Medication (To Be Completed by Parent/Guardian)			

THIS REQUEST IS TO BE EFFECTIVE FOR THE SCHOOL YEAR 20_____ - 20_____ OR FROM _____ TO _____
Only **ONE** medication may be selected. Only **2 doses** of the medication are allowed on person

Medication to be Administered by Mouth	Dosage and Times	Symptons	Comments	Expiration Date of Medication
Acetaminophen (Tylenol) ☐ YES ☐ NO	Administer according to the manufacture's label	For relief of minor aches and pain; (100.4 temperature will not be treated in school)	Student with temperature over 100.4 must be sent home	
Calcium Carbonate ☐ YES ☐ NO	Administer according to the manufacture's label	For stomach ache or heart burn	Alert: May cause constipation	
Ibuprofen (Advil, Motrin) ☐ YES ☐ NO	Administer according to the manufacture's label	For the relief of body aches & menstrual cramps; (100.4 temperature will not be treated in school)	Alert: Contains no aspirin but should not be given if student has asthma or allergy to aspirin	
Midol ☐ YES ☐ NO	Administer according to the manufacture's label	Menstrual cramps	Alert: Aspirin sensitive students should be careful	
Allegra ☐ YES ☐ NO	Administer according to the manufacture's label	For relief of the symptoms of seasonal allergies (sneezing, itching, runny nose)	Alert: Avoid taking any other cold or allergy medicine unless your doctor has told you to	
Lactaid ☐ YES ☐ NO	Administer according to the manufacture's label	Lactose intolerance	No common side effects when used in small doses	
Claritin ☐ YES ☐ NO	Administer according to the manufacture's label	For relief of the symptoms of seasonal allergies (sneezing, itching, runny nose)	Alert: Avoid taking any other cold or allergy medicine unless your doctor has told you to	

III. Parental Permission (To be completed by Parent/Guardian only)

By signing below, I (the parent or legal guardian) understand that the selected over-the-counter medications with parent only permission will be self-carried and self-administered by the student. I understand that if I permit my child to self-carry and self-administer medication, I assume full responsibility for any consequence resulting from medication administration by my child. I understand that all medication must be in the original container and clearly labeled with the student's full name. I understand and have discussed with my son/daughter that if he/she uses the OTC medication in excess of the authorized two (2) daily doses, sells or transmits this medication, he/she will receive the consequence as outlined in the District's Discipline Matrix. By signing this form, I assume full responsibility of any consequence resulting from the self-carry and self-administration of the selected over-the-counter medications. I am also releasing The School Board of Broward County, Florida from any liability that results in my son/daughter using the medication in excess of the authorized doses, selling or transmitting any of the medications identified above.

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ Relationship to the Student _____

Home Phone _____ Business/Mobile Number _____

Email Address _____

IV. Student Acknowledgement (To be completed by Student only)

Student Name (Print) _____

Student Signature _____

V. To Be Completed by Notary Public Only

STATE OF FLORIDA

COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by

_____.

Personally Known _____ OR Producted Identification _____

Tyoe of Identification Producted _____

(Notary Seal)

_____
Offical Notary Signature

_____
Printed Name of Notary

Authorization for Over-the-Counter (OTC) Topical Products with Parental Approval (All Grades)

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Authorization for Over-The-Counter (OTC) Topical Products with Parental Approval Form (All Grades)

Effective for School Year 20_____ - 20 _____

Instructions: Each section must be completed by parent/guardian for student to self-carry and self-administer any of the listed Over-the-Counter Topical Products with parental approval only. The form is void if any section is incomplete.

I. Student/Parent Information

Student's Name (Print Name)	Birth Date	Allergies	Grade

Parent/Guardian (Print Name)	Address:

Home Phone:	Work Phone:	Other Phone:

To Be Completed by Parent/Guardian

NO AEROSOL OR PUMP PRODUCTS PERMITTED

Bug, Insect & Mosquito Repellent Self-carry and self-administration of wipes, towelettes or lotions only Parent Initial: _____	Administer according to the manufacture's label
Sunscreen Products Self-carry and self-administration Parent Initial: _____	Administer according to the manufacture's label

Parental Permission (To be completed by Parent/Guardian only)

By signing below, I (the parent or legal guardian) understand that the over-the-counter topical products with parent only permission will be administered by the student and not by healthcare personnel. I take full responsibility that the topical product that I have signed for is age-appropriate. I understand that I may permit my child to self-carry and self-administer the above listed topical products and I assumed full responsibility for any consequence resulting from topical products administration by my son/daughter. I understand that all topical products must be carried on self, in the original sealed container and clearly labeled with the student's full name. I understand and have discussed with my son/daughter that if he/she inappropriately uses, sells or transmis the topical products, he/she will be issued a consequence as outlined in the District's Discipline Matrix. By signing this form, I assume full responsibility of any consequence resulting from the administration of the above listed topical products. I am also releasing The School Board of Broward County, Florida from any liability that results in my son/daughter inappropriately using, selling or transmitting the topical products identified above.

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ Relationship to the Student _____

Home Phone _____ Business/Mobile Number _____

Email Address _____

Health Screening Opt-Out Form (Grades KG, 1st, 3rd and 6th)

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Health Screening Opt-Out Form

According to the guidelines established by the Florida Legislature, at the beginning of each year, parents shall be notified of the screening activities available through the **School Health Services Program.** Florida Statue 381.0056(7)(d), mandates health screening to public school students in Kindergarten (KG), 1st, 3rd and 6th grades and for students new to the county. It should be understood that such screenings do not substitute for a thorough examination by a health care provider.

The screenings include vision, hearing, height and weight, Body Mass Index (BMI) and Scoliosis. They are offered in an effort to decrease health barriers to learning and may be performed individually or in groups. **Parents or guardians have the right to opt their child out of the screenings.**

Note: If you DO NOT want your child to receive one or more of the screenings, please check the appropriate box below, print and sign your name, and return this form to your child's school WITHIN 10 DAYS FROM THE FIRST DAY OF SCHOOL or from the date of enrollment, if a student enrolls after the start of each school year.

Student Name _____ Gender _____

School _____ Grade _____

DO NOT SCREEN:

- ☐ **Vision (Grades KG, 1st, 3rd and 6th)**
- ☐ **Hearing (Grades KG, 1st and 6th)**
- ☐ **Height and Weight / BMI (Grades 1st, 3rd and 6th)**
- ☐ **Scoliosis (Grade 6th)**

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____

Date _____

Florida Heiken Children's Vision Program Form (All Grades)

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Florida Heiken Children's Vision Program
(Broward Free Eye Exam & Eyeglasses School Program)

If your child fails a vision screening and is eligible, the Florida Heiken Children's Vision Program and its health care providers may provide him/her with a **FREE**, non-invasive, dilated vision exam, and if needed, **FREE** eyeglasses. To apply to receive this **FREE** service, complete, sign and return this form to your child's school. For more information call 1-888-996-9847 or visit http://miamilighthouse.org/Florida_Heiken_Program.asp.

School (Full Name) _____ Grade_____Teacher _____ Student I.D. _____
Student's Name_____ Male/Female (Circle One) Student's Date of Birth _____
Address _____ Apt._____ City _____ Zip Code _____
Home Phone _____ Parent/Guardian Day Phone _____
Parent/Guardian Name (Print) _____ E-mail Address _____
Ethnicity (Circle One): African-American Asian Hispanic Native-American White (Non-Hispanic) Haitian Other _____
Spoken Language (Circle One): English Spanish Creole Portuguese Other _____
Has your child seen an eye doctor in the past year? Yes_____ No _____ Does your child wear glasses? Yes _____ No _____
Please list any medication or eye drops your child uses: _____
Please list any allergies your child has: _____
Does your child have any special needs/developmental delays? Yes _____ No _____ Explain: _____
Does your child require any auxiliary aids (such as interpreter, sign language, visual aids, wheelchair, Braille)? Yes _____ No _____ If Yes, please explain: _____

Has your **child** had any of the following:

YES	NO	
☐	☐	Eye Surgery / Injury
☐	☐	Vision Therapy
☐	☐	Headaches
☐	☐	Glaucoma
☐	☐	Diabetes
☐	☐	Sickle Cell
☐	☐	Asthma

Has your child's **family** had any of the following:

YES	NO	
☐	☐	Eye Turn / Lazy Eye
☐	☐	Blindness
☐	☐	Macular Degeneration
☐	☐	Glaucoma
☐	☐	High Blood Pressure
☐	☐	Sickle Cell
☐	☐	Other

Please explain any "YES" answers from above: _____

Consent for eye examinations - By signing below, I authorize Florida Heiken Children's Vision Program to provide my eligible child with a comprehensive dilated eye examination, either at the school site by a mobile Optometrist or at the office of an assigned participating provider.

Notice of privacy practices - By signing below, I understand that the Notice of Privacy Practices for the Florida Heiken Children's Vision Program is available for review, if I should request a copy via phone at (305) 856-9830/ (888) 996-9847.

Mutual exchange of information - By signing below, I authorize the mutual release of information between the Florida Heiken Children's Vision Program and Broward County Public Schools (BCPS) of any and all optometry medical reports on my child to participating program providers, to determine appropriate care. I also authorize BCPS to release any required information on my child's eligibility for the free/reduced lunch program and any missing or unclear information requested to process this application. **I/We release and hold harmless the County School Board of any and all responsibility and liability for any injury or claim resulting from participation in the Florida Heiken Children's Vision Program because of accident or mishap involving the participation of my child/ward in the program.**

LEGAL GUARDIAN SIGNATURE (to receive exam) _____ **Date:** _____

Authorization to bill insurance - If my child has an insurance plan that is accepted and has an opportunity to be seen on a mobile unit visit (only), I hereby authorize Florida Heiken Children's Vision Program to bill my child's insurance for a comprehensive, dilated eye exam and eyeglasses. If prescribed (includes selected frames, clear poly lenses and no add-ons). I understand this will use my child's insurance vision benefit.

Signature (Authorization to bill insurance) _____ Date: _____

The Florida Heiken Children's Vision Program is an equal opportunity organization and does not discriminate against otherwise qualified applicants on the basis of race, color, religion, ancestry, age, sex, marital status, national origin, disability or veteran status.

For School Personnel Use Only:
County: **Broward**
Referring school/agency: _____
Vision Screening Fail Date (Mandatory): _____
Qualifies for Free/Reduced Program (Circle One): YES NO
Signature: _____ **Date:** _____

For Heiken Use Only: Scanned ☐
Account #: _____
Eligibility Status: _____
Eligibility Date: _____
Insurance: _____

School/Agency: Please fax completed form with Heiken Fax Cover Sheet to (305) 856-9840 / 1(888) 980-8474