THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

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

Authorization for Medication/Treatment
Respiratory Form

PART I TO BE COMPLETED BY PARENT/GUARDIAN

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. I give permission to contact the physician/health care provider prescribing this medication(s) to clarify information provided on the authorization should the need arise. *NOTE: School personnel may administer only treatments authorized by a physician/healthcare provider. It is the parent/guardian's responsibility to notify the school when there is a change in treatment regimen.*

School _____

Student Name _____ Date of Birth _____ Grade _____

Parent/Guardian Signature _____ Phone # _____ Date: _____

PART II TO BE COMPLETED BY PHYSICIAN/PROVIDER

This section is to be completed by the physician when specific nurse/trained personnel expertise is needed to administer medications and/or treatments to students within the school day. When applicable, a review of this order will be conducted by the Individualized Education Plan (IEP) team for determination of support and services to be provided to this student.

Diagnosis:	Allergies:
☐ Artificial Airway Type: _____ Size: _____	☐ Oxygen Oxygen delivered via: ☐ Nasal Cannula ☐ Face Mask Oxygen Flow Rate: _____ Liters Per Minute (LPM)
☐ Ventilator Type: _____ Model: _____	☐ Pulse Oximeter Monitoring Frequency: _____ Keep Oxygen saturations above _____ %
Pressure Support: _____ Pressure/IPAP: _____	☐ CPT
Tidal Volume: _____ Respiratory Rate: _____	Frequency: _____
FIO2/LPM: _____ PEEP/EPAP: _____	
Inspiratory Rate: _____ Low Minute Volume: _____	
High Pressure: _____ Low Pressure: _____	
☐ Suctioning ☐ Oral/Nasal ☐ Tracheostomy	☐ BiPAP/CPAP Settings: _____
☐ Nebulizer Please specify order: _____ As needed/Daily for _____ (Please circle one)	☐ Inhaler Please specify order: _____ As needed/Daily for _____ (Please circle one)

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

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 Telephone # _____ Physician's Fax # _____

Date Completed _____