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
Gastrointestinal/Genitourinary (GI/GU) 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:
☐ G-Tube G-Tube Type: _____ Size: _____ FR Length: _____ cm Balloon Volume: _____ mL ☐ Oral feeds tolerated ☐ Nothing by mouth ☐ Not accessed during school hours Type(s) of oral feeds tolerated: _____ Tube feeding formula: _____ Feeding amount: _____ - _____ Delivered via: ☐ Pump _____ mL/hr ☐ Gravity Frequency: _____ Water flush: _____ mL Frequency: _____ If G-Tube becomes dislodged and student is receiving services of trained one to one nurse, nurse may replace G-Tube: ☐ Yes ☐ No Specify Instructions: _____ - _____ _____ - _____	Ostomy Care Instructions: _____ Catheterization: ☐ Indwelling ☐ Suprapubic ☐ Condom ☐ Mitrofanoff ☐ Straight ☐ Urostomy Catheter Size: _____ Frequency: _____

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 _____

Revised June 2020