

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)

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	<input type="checkbox"/> G-Tube <input type="checkbox"/> J-Tube <input type="checkbox"/> NG-Tube <input type="checkbox"/> Special _____			
Suctioning	<input type="checkbox"/> Oropharynx			
	<input type="checkbox"/> Tracheostomy <input type="checkbox"/> Deep <input type="checkbox"/> Surface			
Tracheostomy	<input type="checkbox"/> Tube Replacement			
	<input type="checkbox"/> 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)