THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

Health Education Services, 600 SE 3 Avenue, 7th Floor, Ft. Lauderdale, FL 33301 Phone: (754) 321-2272

AUTHORIZATION FOR MEDICATION/TREATMENT

Student's Name:________________________________Date of Birth:____________Grade:______________

School: Cooper City High School Phone #:________________Fax #: ____________________________

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Allergies:____

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Diagnosis:____

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MEDICATION	**DOSAGE & ROUTE**	**FREQUENCY**	**SPECIFIC TIMES**	**SPECIAL INSTRUCTIONS/SIDE EFFECTS**

TREATMENTS DURING SCHOOL HOURS

Treatment Plan:____

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PROCUDURE	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				
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 on and is competent to perform__________________________

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List any limitations / precautionary measure that should be considered; e.g. physical education, outdoor activities, transporting, lifting, moving, special devices / equipment:____________________________________

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List any emergency precautions / health emergencies that should be anticipated for this student: e.g. allergy triggers, diabetic reactions, etc.):____

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There are no extraordinary emergency medial services available at school. Since only CPR and first aid are available until 911 arrive, is this adequate for student survival ☐ YES ☐ NO, if "NO", specify: ____________

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______________________________	______________________________
Physician's Name (Printed)	**Physician's Signature**
______________________________	______________________________
______________________________	**Physician's Telephone & Fax Nos.**
______________________________	______________________________
Physician's Office Address	**Date Completed**

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This information will be obtained by School District Personnel

PARENTAL PERMISSION FOR MEDICATION / TREATMENT

(TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN)

Student's Name:_____________________ Date of Birth:_______________Grade:_____________

School: Cooper City High School Phone #:____________________Fax #:_________________

I grant the principal or his / her designee the permission to assist or perform the administration of each medication or treatment / procedure to or for my child during the school day including when he/she is away from school property for official school events.

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/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 medication / treatment regimen.

______________________________	______________________________
Parent / Guardian Name (Printed)	Signature of Parent / Guardian
______________________________	
Date Signed	
______________________________	______________________________
Home Phone Number	Work Phone Number (Include ext. if any)

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Other numbers where you may be reached during school hours (Include cellular phone and beeper)