

Authorization for Treatment 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

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

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)