THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
1400 N.W. 14th Court • Fort Lauderdale, Florida 33311 • Office: 754-321-1575 • Fax: 754-321-1696

Coordinated Student Health Services
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Dear Parent,

The following information is to assist you, as the parent/guardian, with providing health information required for your child by Broward County Public Schools. If you should have any questions, please feel free to contact your school.

COVID-19 Vaccination
If your child has been fully vaccinated, you may voluntarily notify your school. This would assist with COVID-19 screening of close contacts.

Medical Examination
All students entering Broward County Public Schools for the first time must have a medical examination performed within one year of registration. The medical examination should be documented on the Florida Department of Health Form 3040 or on the provider's office/ medical facility stationery. The appropriate form/stationary should be completed, signed and dated by the healthcare provider.

Communicable Diseases/Illnesses
Please inform the school if your child is out sick with a diagnosed communicable illness such as COVID-19, meningitis, measles, salmonella, etc.

Please keep your child home if your child has:
- Flu-like symptoms
- Fever greater than 100.4 degrees
- Persistent cough
- Headache
- New loss of taste or smell
- Shortness or breath/difficulty breathing
- Chillis
- Muscle or body aches
- Vomiting
- Diarrhea
- Fatigue
- Congestion or runny nose
- Sore throat
- Rashes, yellow eye drainage, or greenish-yellow phlegm from

Chronic Health Conditions
If your child has any of the following health conditions, including, but not limited to, asthma, diabetes, cystic fibrosis, sickle cell anemia,

seizures, allergic reactions to food, insect bites, etc., please inform the school.

Parents should:

- Document the chronic health condition on the Student Emergency Contact Card and complete the history on the back of the card
- Meet with school administration to discuss care of the student while at school
- Provide the school with a current Medication Authorization form signed by the healthcare provider and parent, if the student is on medication

Note: A Diabetes Medication/Treatment Authorization form must be completed by the healthcare provider and parent for students with diabetes. Students who received insulin via an insulin pump must also complete an Insulin Pump Medication/Treatment Authorization form.

Medication Administration at School (Prescription or Over-the-Counter)

- No medication will be administered in school or during school-sponsored activities without the parent's/guardian's written authorization and a written authorized prescriber order. This includes both prescription and over-the-counter (OTC) medications
- The parent/guardian is responsible for filling out Part I and obtaining the authorized prescriber's order and signature on Part II. A new Medication Authorization form must be completed every 12 months or when changes are made to an existing Medication Authorization. Information necessary includes student's name, diagnosis, allergies (specify none or n/a if there aren't any), medication name, strength of medication, dosage, time of administration, route of administration, possible side effects, prescriber's signature and date
- All medications will be administered by onsite healthcare personnel or by a trained school staff member designated by the principal
- The medication must be delivered to the school by the parent/guardian or, under special circumstances, an adult designated by the parent/guardian. All medication must be signed into the clinic by the parent/guardian and counted with the school health nurse or school personnel. Medication delivered by the student will not be administered by the school health nurse or school personnel
- All prescription medication must be provided in an original pharmacy container with the pharmacy label attached. The pharmacy label cannot be expired. Non-prescription OTC medication must be received in the original packaging with the safety seal intact
- The first day's dosage of any new non-emergency medication must have been given at home before it can be administered at school
- The parent/guardian is responsible for collecting any unused portion of a medication after expiration date of the medication or expiration date of the authorized prescriber's order. If the medication is unclaimed by the parent/guardian after three contact attempts, the medication will be forwarded to the Risk Management department and will be destroyed
- An authorized prescriber's order and parent/guardian permission are necessary for self-carry/self-administered emergency medications such as inhalers for asthma or epinephrine auto-injectors/Auvi-q auto injectors for anaphylaxis. **It is imperative that the student understands the necessity for reporting to either the school nurse or school staff members that they have self-administered their inhaler without any improvement or have self-administered an epinephrine/Auvi q auto injector so 911 may be called**
- The school nurse will call the authorized prescriber, as allowed by the Health Insurance Portability and Accountability Act (HIPAA), if a question arises about the student and/or the student's medication

Authorization for Selected Over-the-Counter Medication (OTC) with Parental Approval (Grades 9-12 Only)

If your child needs to take over-the-counter (OTC) medication at school or on a field trip, an Authorization for Selected Over-the-Counter Medication (OTC) with Parental Approval form must be completed and signed by the parent/guardian, student and be notarized.

- Self-carry, self-administration of the selected over-the-counter medications only:
  - Tylenol
  - Midol
  - Ibuprofen
  - Tums
  - Allegra
  - Claritin
  - Lactaid

Authorization for Over-the-Counter (OTC) Topical Products with Parental Approval

- Students in all grade levels are permitted to self-carry and self-administer bug, insect, mosquito repellent (wipes, towelettes or lotions only)and sunscreen (no aerosol products permitted)
- An Authorization for Over-the-Counter (OTC) Topical Products with Parental Approval Only form must be completed and signed by theparent/guardian

Note: Plan ahead for field trips if your child needs medication for an overnight trip that he/she may not normally take at school. Update changes to your child's health condition as they occur.

Immunizations (Please refer to F.S. 1003.22)

- Make sure your child's required immunizations are up to date. If you are not sure, you can check with your healthcare provider or the Florida Department of Health-Broward at (954) 467-4700

- Parents may obtain medical exemptions from their healthcare provider or a religious exemption from the Florida Department of Health-Broward

School Health Centers, Community Resources, Immunizations & Health Care

- Information is available on Broward County Public Schools website at http://www.browardhealthservices.com/resources/
- If you do not have insurance, you can request an application for Florida KidCare Insurance at your child's school
- The Florida Heiken Children's Vision Program provides vision examinations and eyeglasses when prescribed, to students in need of comprehensive vision services at no cost to the student
- Eligible students for the program must meet the criteria of the Free and Reduced Lunch Program and have failed the vision screening
- The Florida Children's Vision Program consent form will be sent home during the first week of school for parent/guardian signature
- If your child meets the above criteria and you would like your child to participate in the program, please complete, sign and return the consent form to the school

Additional information on school entry requirements is available at http://www.browardhealthservices.com/parent-information/registration-requirements/.
If you have any questions, please contact your child's school.

Authorization for Medication Form 2021/2022 (All Grades)

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Authorization for Medication/Treatment
Prescription or Over-the-Counter (OTC) Medication

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 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. If my child is unable to self-administer their medication, I give permission for the principal/designee to perform the administration of the prescribed medication. I give permission to contact the physician/provider prescribing this medication(s) to clarify information provided on the authorization should the need arise.

Student Name _____ Date of Birth _____ Grade _____

School _____

Parent/Guardian Signature _____ Phone # _____ Date _____

PART II: TO BE COMPLETED BY PHYSICIAN/PROVIDER

Allergies _____

Diagnosis _____

MEDICATION	STRENGTH	DOSAGE	TIME(S) TO BE GIVEN	ROUTE	SIDE EFFECTS

Please check the appropriate box:

- ☐ I believe that this student has received adequate information on how and when to use their medication and they can use it properly.
- ☐ The student is to carry the medication on their person with the principal's knowledge. (An additional supply, to be used as backup may be kept in the school health room or other approved locations)
- ☐ The medication will be kept in the school health room.

Please list any limitations/precautions that should be considered _____

_____

Physician's Name (Print) _____ Physician's Signature _____

Physician's Telephone # _____ Physician's Fax # _____

Date Completed _____

PART III: TO BE COMPLETED BY SCHOOL HEALTH NURSE/DESIGNEE

Check as appropriate:

- ☐ Parts I and II are completed in entirety, including signatures.
- ☐ Prescription medication is property labeled by pharmacist.
- ☐ Medication authorization and medication label are consistent and pharmacy label is **NOT** expired.
- ☐ Over-the-counter medication is in an original container with the manufacturer's dosage and label, labeled with student's name and safety seal is intact.
- ☐ Medication has been signed into clinic by parent and counted with school staff member.

_____ _____ _____

School Designee/Healthcare Personnel (Print) School Designee/Healthcare Personnel (Signature) Date

Authorization for Over-the-Counter (OTC) Topical Products with Parental Approval (All Grades) 2021/2022

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Authorization for Over-The-Counter (OTC) Topical Products with Parental Approval Form (All Grades)

Effective for School Year 20_____ - 20 _____

Instructions: Each section must be completed by parent/guardian for student to self-carry and self-administer any of the listed Over-the-Counter Topical Products with parental approval only. The form is void if any section is incomplete.

I. Student/Parent Information

Student's Name (Print Name)	Birth Date	Allergies	Grade

Parent/Guardian (Print Name)	Address

Home Phone	Work Phone	Other Phone

To Be Completed by Parent/Guardian

NO AEROSOL OR PUMP PRODUCTS PERMITTED

Bug, Insect & Mosquito Repellent Self-carry and self-administration of wipes, towelettes or lotions only Parent Initial: _____	Administer according to the manufacture's label
Sunscreen Products Self-carry and self-administration Parent Initial: _____	Administer according to the manufacture's label

Parental Permission (To be completed by Parent/Guardian only)

By signing below, I (the parent or legal guardian) understand that the over-the-counter topical products with parent only permission will be administered by the student and not by healthcare personnel. I take full responsibility that the topical product that I have signed for is age-appropriate. I understand that I may permit my child to self-carry and self-administer the above listed topical products and I assume full responsibility for any consequence resulting from topical products administration by my son/daughter. I understand that all topical products must be carried on self, in the original sealed container and clearly labeled with the student's full name. I understand and have discussed with my son/daughter that if he/she inappropriately uses, sells or transmits the topical products, he/she will be issued a consequence as outlined in the District's Discipline Matrix. By signing this form, I assume full responsibility of any consequence resulting from the administration of the above listed topical products. I am also releasing The School Board of Broward County, Florida from any liability that results in my son/daughter inappropriately using, selling or transmitting the topical products identified above.

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ Relationship to the Student _____

Home Phone _____ Business/Mobile Number _____

Email Address _____

Authorization for Respiratory Treatment Form 2021/2022 (All Grades)

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Authorization for MedicationTreatment - Respiratory Treatment 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, 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 _____ Pressure Support _____ Pressure/IPAP _____ Tidal Volume _____ Respiratory Rate _____ FIO2/LPM _____ PEEP/EPAP _____ Inspiratory Rate _____ Low Minute Volume _____ High Pressure _____ Low Pressure _____	☐ Pulse Oximeter Monitoring Frequency _____ Keep Oxygen saturations above ____% ☐ CPT Frequency: _____
☐ Suctioning ☐ Oral/Nasal ☐ Tracheostomy	☐ BiPAP/CPAP Settings: _____
☐ Nebulizer Please specify order _____ (**Please circle one**) As needed/Daily for _____	☐ 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, specify: _____

Physician's Name (Print) _____ Physician's Signature _____

Physician's Telephone # _____ Physician's Fax # _____

Date Completed _____

Authorization for Gastrointestinal/Genitourinary Treatment Form 2021/2022 (All Grades)

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Authorization for Medication/Treatment - Gastrointestinal/Genitourinary (GI/GU) Treatment 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, 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

☐ 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 _____
_____

Allergies

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, specify _____

Physician's Name (Print) _____ Physician's Signature _____

Physician's Telephone and Fax # _____ Date Completed _____