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
Gail Adams, Director (Task Assigned)
www.browardschools.com
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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.

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
- Chills
- Muscle or body aches
- Nausea
- 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

- Provide the school with the medications listed on the current Medication Authorization form in the original container.

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.
- 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 the parent/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.

Additional information on school entry requirements is available at https://www.browardschools.com/Page/56759. If you have any questions, please contact your child's school.

Authorization for Medication Form 2022/2023 (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 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 Selected Over-the-Counter (OTC) Medication with Parental Approval (Grades 9-12) 2022/2023

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

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

Instructions: Each section must be completed by parent/guardian for student to self-carry or self-administer any of the selected over-the-counter (OTC) medication with parental approval only. The form is void if any section is incomplete. This form is to be signed by the parent/guardian, student and notarized.

I. Student/Parent Information

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

Parent/Guardian (Print Name)	Address

Home Phone	Work Phone	Other Phone

II. Medication (To Be Completed by Parent/Guardian)

THIS REQUEST IS TO BE EFFECTIVE FOR THE SCHOOL YEAR 20_____ - 20_____ OR FROM _____ TO _____

Only ONE medication may be selected. Only 2 doses of the medication are allowed on person

Medication to be Administered by Mouth	Dosage and Times	Symptoms	Comments	Expiration Date of Medication
Acetaminophen (Tylenol) ☐ YES ☐ NO	Administer according to the manufacturer's label	For relief of minor aches and pain; (100.4 temperature will not be treated in school)	Student with temperature over 100.4 must be sent home	
Calcium Carbonate ☐ YES ☐ NO	Administer according to the manufacturer's label	For stomach ache or heart burn	Alert: May cause constipation	
Ibuprofen (Advil, Motrin) ☐ YES ☐ NO	Administer according to the manufacturer's label	For the relief of body aches & menstrual cramps; (100.4 temperature will not be treated in school)	Alert: Contains no aspirin but should not be given if student has asthma or allergy to aspirin	
Midol ☐ YES ☐ NO	Administer according to the manufacturer's label	Menstrual cramps	Alert: Aspirin sensitive students should be careful	
Allegra ☐ YES ☐ NO	Administer according to the manufacturer's label	For relief of the symptoms of seasonal allergies (sneezing, itching, runny nose)	Alert: Avoid taking any other cold or allergy medicine unless your doctor has told you to	
Lactaid ☐ YES ☐ NO	Administer according to the manufacturer's label	Lactose intolerance	No common side effects when used in small doses	
Claritin ☐ YES ☐ NO	Administer according to the manufacturer's label	For relief of the symptoms of seasonal allergies (sneezing, itching, runny nose)	Alert: Avoid taking any other cold or allergy medicine unless your doctor has told you to	

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

By signing below, I (the parent or legal guardian) understand that the selected over-the-counter medication with parent only permission will be self-carried and self-administered by the student. I understand that if I permit my child to self-carry and self-administer medication, I assume full responsibility for any consequence resulting from medication administration by my child. I understand that all medication must be in the original container and clearly labeled with the student's full name. I understand and have discussed with my son/daughter that if he/she uses the OTC medication in excess of the authorized two (2) daily doses, sells or transmits this medication, he/she will receive the consequence as outlined in the District's Discipline Matrix. By signing this form, I assume full responsibility of any consequence resulting from the self-carry and self-administration of the selected over-the-counter medications. I am also releasing The School Board of Broward County, Florida from any liability that results in my son/daughter using the medication in excess of the authorized doses, selling or transmitting any of the medication identified above.

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ Relationship to the Student _____

Home Phone _____ Business/Mobile Number _____

Email Address _____

IV. Student Acknowledgement (To be completed by Student only)

Student Name (Print) _____

Student Signature _____

V. To Be Completed by Notary Public Only

STATE OF FLORIDA

COUNTY OF _____

The foregoing instrument was acknowledged before me this __ day of _____, 20_____, by

_____.

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

(Notary Seal)

_____
Offical Notary Signature

_____
Printed Name of Notary

Authorization for Over-the-Counter (OTC) Topical Products with Parental Approval (All Grades) 2022/2023

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

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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 2022/2023 (All Grades)

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

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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 2022/2023 (All Grades)

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

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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 _____

Parent/Guardian Consent for Health Services Form 2022/2023 (All Grades)

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

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Parent/Guardian Consent for School Health Services Form

- This consent will remain in effect until your child transfers to another school district, graduates or you indicate in writing that you wish to rescind this consent for school health services.
- When necessary, emergency health services such as first aid, cardiopulmonary resuscitation (CPR) or use of an automated external defibrillator (AED) will be performed until emergency medical services arrive on campus.
- Separate parent/guardian authorizations will be required for the school clinic staff or school staff to administer daily or as-needed prescribed or over-the-counter medications, conduct medical procedures or provide medical treatment.

THIS FORM MUST BE COMPLETED AND RETURNED TO THE SCHOOL CLINIC IF YOU CONSENT AND WISH FOR YOUR CHILD TO RECEIVE ANY OF THE SCHOOL HEALTH SERVICES LISTED BELOW.

Print all information using an ink pen

Student Information

				Male ☐
First Name	Middle Name	Last Name	Student Birth Date	Female ☐
Street Address	Apartment Number	City	State	Zip Code
Home Phone	Work Phone		Cell Phone	

Indicate which services you give consent and would like your child to receive at school with an "x" in the check boxes.

	Yes	No
Care and treatment for illness and injury	☐	☐
Vision screening	☐	☐
Hearing screening	☐	☐
Growth and development screening (body mass index)	☐	☐

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____

Date _____