BROWARD COUNTY PUBLIC SCHOOLS
AUTHORIZATION FOR MEDICATION

Name of Student: _____ Date of Birth: _____ Grade: _____
Phone #: _____
School: _____ Fax #: _____ Date: _____

****

MEDICATION TREATMENT PLAN
TO BE COMPLETED BY PHYSICIAN

Diagnosis: _____

_____

Medication, Dosage, Specific Times & Direction for Administration: _____
(*Please write each medication, dosage, frequency and time separately.)

_____

_____

_____

NOTE: **Medication must be supplied in the original prescription container**. Ask pharmacist to divide the medication into two completely labeled containers, providing one for home and one for school.

Side Effects/Special Instructions: _____

_____

_____

*Note to Physicians: Please complete the treatment plan on the back of this form for students who require any special health procedures during school hours; i.e., inhalers, nebulizer treatments, catheterization, suctioning, tube feedings, glucose testing, etc.

_____ _____
Printed Name or Stamp of Physician Physician's Signature

_____ _____
Physician's Phone Number Physician's Fax Number

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PARENTAL PERMISSION
TO BE COMPLETED BY PARENT/GUARDIAN

I grant the principal or his/her designee the permission to assist in the administration of each prescribed medication/procedure to be provided during the school day, including when _____
Name of Student
is away from school property on official school business.

_____ _____
Signature of Parent Date

Home Phone Number: _____
Work Phone Number: _____

Form: #2240E
Revised: 4/96

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Name of Student: _____ Grade: _____

TREATMENT FOR STUDENTS NEEDING HEALTH PROCEDURES DURING SCHOOL HOURS

Treatment Plan: _____

_____

_____

_____

Special Procedures (List special procedures in which students have been trained; e.g., insulin administration, use of Epi-pen, nebulizer, testing glucose levels, etc.): _____

_____

_____

Catheterization: type: _____ frequency: _____

Feedings: type: _____ rate/flow: _____ frequency/time: _____ amount: _____

Suctioning: type: _____ frequency/time: _____

_____

_____

Please list any limitations/precautionary measures that should be considered; e.g., physical education, outdoor activities, transporting, lifting, special devices/equipment: _____

_____

_____

_____

_____

Please state any emergency precautions/health emergencies that should be anticipated for this student; (e.g., allergy triggers, diabetic reactions, etc.) _____

_____

_____

What is the care plan for these identified emergencies? _____

_____

_____ _____

Physician's Signature Date

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