AUTHORIZATION FOR MEDICATION FORM

FLORIDA CHRISTIAN SCHOOL
4200 SW 89TH AVE., MIAMI, FL 33165
305 – 226-8152 EXT 277

THE FOLLOWING SECTIONS IS TO BE COMPLETED BY THE PARENT OR LEGAL GUARDIAN:

I hereby grant permission to the school nurse or his/her designee of **FLORIDA CHRISTIAN SCHOOL** to assist in the administration of the prescribed medication to my child while in school and away from school while participating in official school activities (field trips). It is my responsibility to notify the school if and when these orders change. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinarily reasonable prudent person while under the same or similar circumstances.

Student Name: ____

Parent's/Guardian's Name: ____ Relationship: ____________________________________

Address: ____ Phone: ____

Parent's/Guardian's Signatures: ____

The following section is to be completed by the Healthcare Practitioner (Physician, Advance Registered Nurse Practitioner, and/or Physician Assistant). A SEPARATE FORM MUST BE COMPLETED FOR EACH MEDICATION PRESCRIBED.

The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following medication, which is necessary to be given in school during the hours of 8 am – 3 pm when parent/guardian cannot be present to administer the medication. I am aware that trained non-medical staff may administer this Healthcare Practitioner Prescribed service.

PLEASE TYPE OR PRINT;
This order is to be effective for the school year: 20____ - 20____ or earlier stop date: _________________________

DIAGNOSIS AND PURPOSE FOR THIS MEDICATION:

Allergies: NO ⬠ YES ⬠ PLEASE SPECIFY ALLERGY:

Name of Medication:	**Strength(i.e. mg/tab):**

Instructions to give: (please specify exact dosage & frequency)

Frequency: ____ Duration: ___________________________________

Dose: ____ Time: ______________________________________

Route: __ Oral __ Topical __ Subcutaneous __ I.M . __ Inhaled __ Other (describe) ___________________________________

____

Side Effects: ____

Circle One:
*Is student authorized to carry and use asthma medication, Epi-Pen, or Pancreatic enzymes? YES NO
*Has student been instructed in the use of asthma medication, Epic-Pen, or Pancreatic enzymes by practitioner: YES NO

***If YES; Explain :____

____

Healthcare Practitioner's Signature: ____ **Date:** ______________

Healthcare Practitioner's Name (please print using all caps): ____

Office Address: ____ **City:** _____________ **State** ____________

Office number: ____ **Fax number:** ____

Date Medication stopped by Parent/Guardian: ____________________________ **Signature;** ____________________________________

PHYSICIAN'S REFERAL FOR IN-SCHOOL NURSING SERVICES

REGISTRATION FORM

This form is to be completed by the physician when specific nurse expertise is needed to administer medications and/or treatments to student within the school day.

PATIENT INFORMATION

Student ID number: ___________________________

Last:			First:		Middle:
Birth date: / /	Age:	Sex: ❑ M ❑ F			
Street address:			Apt #:	Home phone no.: ( )	
State:	ZIP Code:				

Name of Parent/Guardian: (Circle One)

Cell #:

Cell #:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to student::	Home phone no.:	Work phone no.:
		( )	( )

Name of local friend or relative (not living at same address):	Relationship to student:	Home phone or Cell phone number

(TO BE COMPLETED BY THE PHYSICIAN)

FLORIDA CHRISTIAN SCHOOL provides nursing services during school hours when these services are required to allow the student to attend a school-based program and if services are needed for the student to access an educational program.

________ **Initial Orders** ________ **Annual Update** _______ **Changed Orders** _______ **Discontinuation**

(To be completed by physician)

Diagnosis (1): ____

Allergies: ____

Precautions (include history of drug reactions): ____

Physician's certification
(to be completed by Physician)

I certify that the nursing services listed in the above sections are recommended in order for the student to attend a school-based program and that these services are needed to access an educational program. I understand that for further clarification of these order, I may be contacted by Florida Christian School Staff.

___________________________________ ____________ ___________________

Physician's Signature Date Office Number

____

Physician's name (please print)

NURSING ORDERS – DIABETES TREATMENT

(to be completed by the physician)

Parent/guardian will be responsible for providing all equipment, supplies, and medications.

Attach the Diabetes/Medication Treatment Plan or complete the information below.

Student has been trained by healthcare professional: ____ Yes _____ No

Blood glucose (BG) testing:

Target range for BG: ____________ Type of Meter: ____________

___ Before lunch ___ Anytime student does not feel well

___ Hours after meals ___ Other: ________________________

___ Before/After exercise ________________________

Insulin Delivery: ____ Syringe/Vial ____ Pen ____ Pump

Calculate insulin does for carbohydrate intake: ___ Yes ___ No

Carbohydrate Coverage: ____ #unit(s) of insulin per ____ grams of carbohydrate.

____ Add carbohydrate does to correction dose at lunch.

<u>INSULIN SLIDING SCALE</u>

Blood Sugar	Dose

Student's Name: ____ School: __________________________________

<u>Parents should return this form to the school nurse.</u>