

Authorization for Gastrointestinal/Genitourinary Treatment Form 2021/2022 (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 - 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	Allergies
<input type="checkbox"/> G-Tube G-Tube Type _____ Size _____ FR Length _____ cm Balloon Volume _____ mL <input type="checkbox"/> Oral feeds tolerated <input type="checkbox"/> Nothing by mouth <input type="checkbox"/> Not accessed during school hours Type(s) of oral feeds tolerated _____ Tube feeding formula _____ Feeding amount _____ Delivered via <input type="checkbox"/> Pump _____ mL/hr <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No Specify Instructions _____ _____	Ostomy Care Instructions _____ Catheterization: <input type="checkbox"/> Indwelling <input type="checkbox"/> Suprapubic <input type="checkbox"/> Condom <input type="checkbox"/> Mitrofanoff <input type="checkbox"/> Straight <input type="checkbox"/> 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 _____