VOLUNTEER HEALTH CARE PRACTITIONER PROGRAM

Volunteer Name: _____ Profession*: _____

Home Phone: _____ Other Phone: _____

School: _____ Date(s) of Event: _____

Professional License Number: _____ (Attach copy)

Indicate when each of the following requirements are completed:

Requirement	Date	Staff Signature
Professional Florida license confirmed as active and valid		
Level 2 background screening completed and passed		
Current CPR Certification		
Statement of Confidentiality Submitted		
Orientation to District medication administration procedures		
Assist in preparation of medications and review of Medication Authorizations		

**The following health care practitioners, licensed under relevant State statutes, (381.00593) may volunteer their professional services to assist students with medication administration during school-sponsored extra-curricular activities:*

- *Physician*
- *Osteopathic physician*
- *Chiropractic physician*
- *Podiatric physician*
- *Advanced registered nurse practitioner*
- *Registered nurse*
- *Licensed practical nurse*

I _____ affirm that I possess a valid Florida license to practice
Name Printed

_____ and I have completed all of the above requirements.
Profession

Signature: _____ Date: _____

Copy to be retained by School Activities Department, School Nurse, Exceptional Education and Student Support Services