The District School Board of Collier County
Authorization for Nursing Care/Treatment

This form provides professional and parental authorization for medical treatment to be provided during school hours. Both the prescribing physician or health care provider and the parent/legal guardian are required to complete the respective sections of this document entirely before the services can be provided.

Student's Name ____________ Sex ______ Date of Birth ______ Student # ______

School ____________ Fax Number ______

Physician's Order for Nursing Care/Treatment

Note: Physician's orders are required for all medical procedures administered at school. Please have your child's physician complete this portion of the form and return it to the school or have them fax it to the school nurse.

The following section is to be completed by the prescribing physician or health care provider:

Diagnosis for which nursing care/treatment will be required in school:	**ICD 10 Code**

Type of nursing care/treatments required in school (please describe any procedures or treatments thoroughly):

Time and frequency of care during school hours:	Duration of care (how long do you anticipate the student will require the nursing care):

Comments about the care:

The student named in this document is under my medical supervision for the diagnosis described above. I have prescribed the care/treatment that is necessary to be given during school hours for the child's health or safety. I am also aware that prescribed care or treatments may be administered by trained non-medical personnel.

Physician's Name (Print):		Phone Number:		Fax Number:	
Physician's Signature:				Date:	
☐ Verbal Order Obtained (state reason for verbal order)		Time:		Date:	
School Nurse's Signature:				Date:	

Parent/Legal Guardian Permission

The following section is to be completed by the parent/legal guardian:

I hereby grant permission to the principal or his/her designee of ______________________ school to assist in the administration of the above prescribed care/treatment to my child while in school and away from school while participating in official school activities (F.S. 1006.062). **It is my responsibility to notify the school if and when these orders change.** I understand that the law provides there shall be no liability for civil damages as a result of the administration of such care/treatment where the person administering such care/treatment acts as an ordinarily prudent person would under the same circumstances.

1. I hereby give permission for my child's doctor or other authorized health care practitioner to be contacted for information regarding my child's illness, health or medical condition that may require nursing care or treatment during the school day or while participating in school related activities.
2. I hereby authorize the school nurse or their appropriately skilled and trained designee to perform any nursing care or treatments that may be prescribed by my child's physician or authorized health care provider for the school day or while my child is participating in school related activities.
3. I understand that I am responsible for providing the equipment, supplies and/or prescribed medications to the school that are required to perform these services for my child during the school day or while away from the school on school related activities.
4. I hereby agree to provide the equipment, supplies and/or prescribed medications for my child either on a daily basis or other schedule as prearranged with school staff members.
5. I understand that all medications, treatments, materials and supplies not picked up the last day of school will be properly disposed.

Parents may provide special instructions below or make recommendations for provision of care/treatment following written physician's orders:

My child has:	☐ No allergies, ☐ The following allergies:	

Parent/Guardian Name:				Relationship:	
Home Phone:		Business Phone:		Emergency Phone:	
Parent/Guardian Signature:				Date:	

Rev 4/15

The District School Board of Collier County
Exceptional Student Education
Authorization for Nursing Care/Treatment

Dear Parent/Legal Guardian:

If your child requires nursing care or treatments to be given during the school day, State Regulations and School Board Guidelines require that you and your doctor provide written permission for provision of these services.

- The nursing care/treatment authorization on the reverse side of this document must be completed entirely for the services to be provided to your child in school or while participating in school related activities. The form must be signed both by a parent/legal guardian and the treating/prescribing doctor as indicated. Staff will not be able to provide nursing services or treatments to you child without this written consent.

Thank you for assisting us to provide safe nursing care and treatments for you child during the school day and while at school related activities.

Please see reverse side of this document for Nursing Care/Treatment Authorization

Student Medical History

Student Name ______________________________________ **Student #** ____________________

DOB ____________ **School** __________ **Grade** ________ **Teacher** ______________________________

Parent/Guardian Name ____ **Bus Rider**: Yes__ No__

Phone (H) ______________________ (W) ______________________ (C) ____________________

PRIMARY MEDICAL DIAGNOSIS:
____
____

Year Diagnosed _________________

SIGNS AND SYMPTOMS THAT MAY PRESENT AT SCHOOL:
____
____

ACTIONS TO BE TAKEN AT SCHOOL:
____
____

CURRENT MEDICATIONS: (Attach additional pages as needed)

Drug Name	*Dose*	*Purpose*
______________________	____________________	____________________
______________________	____________________	____________________
______________________	____________________	____________________
______________________	____________________	____________________

Diastat __________ Epi-pen __________ Other ________________________________

SURGERIES: (Attach additional pages as needed)

Type ____ *Year* ____________
Type ____ *Year* ____________
Type ____ *Year* ____________

HOSPITALIZATIONS: (Attach additional pages as needed)

Reason ____ *Year* ____________
Reason ____ *Year* ____________
Reason ____ *Year* ____________
Reason ____ *Year* ____________

ALLERGIES: (Attach additional pages as needed)

Allergic to	*Reaction*	*Action*
________________	______________________	______________________________
________________	______________________	______________________________
________________	______________________	______________________________

Student Name ______________________________________ **Student #** ________________

PRIMARY PHYSICIAN:
Name: ____
Address: ____
Phone: ________________________________ Fax: ___________________________

MEDICAL SPECIALISTS:
Name: ____ Phone: __________________
Address: ____ FAX: __________________

Name: ____ Phone: __________________
Address: ____ FAX: __________________

Name: ____ Phone: __________________
Address: ____ FAX: __________________

General Health History **Enter dates into any boxes that apply to your child's health history**

Past	Present	
		Accidental injuries/severe head injury
		ADHD
		Asthma/respiratory condition
		Bee sting/insect allergy
		Bladder disorder
		Cancer/Tumor
		Diabetes
		Diarrhea/constipation/toileting issues
		Disorder of the blood
		Ear problems
		Emotional concern
		Eye problems/Glasses
		Food, drug, or environmental allergies

Past	Present	
		Frequent colds/flu
		Hearing problems/Hearing devices
		Heart problem
		Kidney disease
		Muscular disorder
		Seizures/convulsions
		Serious infections/high fevers
		Severe burns
		Severe headaches
		Skin problems
		Swallowing or choking difficulties
		Other:
		Other:

Does your child walk independently? Yes _____ No _____
Is any adaptive equipment required? Yes _____ No _____
If yes, please specify:
____
____
____

Does your child have any dietary concerns or feeding / eating problems? Yes _____ No _____
If yes, specify:
____
____
____
____

Student Name: _______________________ #: ____________

Does you child have any activity restrictions?   Yes _____   No ______ (If yes, please specify)

____

____

____

Toileting? Specify any special needs

____

____

____

Will your child require any medical treatments while at school? (Ex: nebulizer, injections, tube feeding)

____

____

____

The above information is true and complete to the best of my knowledge and I am aware that deliberate misrepresentation may jeopardize my child's health. I understand that this information is confidential and will be shared on a need to know basis. This information is protected by law.

I give permission for my child's health care provider to be contacted for information regarding my child's medical condition. I have reviewed and agree with the information as listed on this Individualized Healthcare Plan.

____ ____________________

Signature of Parent **Date**

____ ____________________

Reviewed by (Nurse Signature) **Date**