THE SCHOOL BOARD OF ST. LUCIE COUNTY, FLORIDA

PHYSICIAN AUTHORIZATION FORM FOR

PANCREATIC (DIGESTIVE) ENZYMES

Part I: (to be completed by physician's office) Date ___/___/___

Name of student_____ DOB ___/___/___

The above named student has cystic fibrosis and must take the following pancreatic enzymes:

[ ] **With each meal: _____**

[ ] **With each snack: _____**

PLEASE CHECK ONE:

[ ] The student is capable of carrying the enzymes and self-administering as needed
OR
[ ] The enzymes should be stored and administered as ordered above by an adult

_____ _____ _____

Physician Signature Date Telephone

Part II: (to be completed by parent/guardian)

I hereby give permission:
* For my child, named in part I, to take the pancreatic enzymes during school hours as ordered.
* To the school nurse to share information with appropriate school staff as he/she determines appropriate for my child's health and safety
* To the school nurse to contact the above health care provider for information relevant to the prescribed treatment s he/she determines appropriate for my child's health and safety.

_____ _____ _____

Parent/Guardian Signature Date Telephone

Part III: (School Use Only)

Health Paraprofessional: _____

Date

Registered Nurse: _____

Date

Principal: _____

Date