AUTHORIZATION FOR TREATMENT

(TO BE COMPLETED BY PHYSICIAN)

Student's Name: ____ **Date of Birth:** ________________________ **Grade:** _______________

School: ____ **Phone #:** _______________________ **Fax#:** ___________________

Allergies: ____

Diagnosis:____

TREATMENTS DURING SCHOOL HOURS

Treatment Plan: ____

PROCEDURE	TYPE	MEDS / FEEDING AMOUNT	FREQUENCY SPECIFIC TIMES	RATE / FLOW
Catheterization				
Feedings	☐ G-Tube ☐ J-Tube ☐ NG-Tube ☐Special ________			
Suctioning	☐ Oropharynx ☐ Tracheostomy ☐ Deep ☐ Surface			
Tracheostomy	☐ Tube Replacement ☐ Care (Cleaning)			
CPT				
Oxygen /Misting				
Ventilator				
Nebulizer Tx				
Pulse Oximeter				

Are any of the above procedures required for emergency care? ☐ YES ☐ NO, IF **"YES",** specify: ____
____

List any procedures the student has been trained to perform ____

List any limitations / precautionary measures that should be considered; e.g. physical education, outdoor activities, transporting, lifting, moving, special devices / equipment: ____
____

List any emergency precautions / health emergencies that should be anticipated for this student; e.g. allergy triggers, diabetic reactions, etc.) :
____
____

There are no extraordinary emergency medical services available at school. Since only CPR and first aid are available until 911 arrive, is this adequate for student survival? ☐ YES ☐ NO, If **"NO"**, specify: ____
____

Physician's Name: ____ **Phone#:** ____________________ **Fax #:** ____________________

Physician's Office Address: ____

____ ________________________________
Physician's Signature **Date Completed**

****

This information will be obtained by School Board District Personnel

PARENTAL PERMISSION FOR TREATMENT

(TO BE COMPLETED BY STUDENT'S PARENT/GUARDIAN)

Student's Name: ____ **Date of Birth:** _________________________ **Grade:** _______________

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. If my child has been authorized by his/her physician to self-administer their medication(s), I grant permission for my child to self-administer their treatment at school and when they are away from school property for official school events. In the event that my child is unable to self-administer their treatment, I give permission for the principal/designee to perform the administration of the prescribed treatment. **NOTE: School personnel may only administer treatments authorized by a physician. It is your responsibility to notify the school when there is a change in treatment regimen**.

Parent / Guardian Name (Printed): _______________________________________

Home Phone #: ________________________ **Cell Phone #:** _______________________ **Work Phone #:** __________________________
(include Ext. if any)

____ ________________________________
Parent / Guardian Signature **Date**