

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 | <input type="checkbox"/> G-Tube <input type="checkbox"/> J-Tube <input type="checkbox"/> NG-Tube <input type="checkbox"/> Special _____ | | | |
| Suctioning | <input type="checkbox"/> Oropharynx <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Deep <input type="checkbox"/> Surface | | | |
| Tracheostomy | <input type="checkbox"/> Tube Replacement <input type="checkbox"/> 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