HEALTH PROCEDURE
AND NURSING CARE AUTHORIZATION

Northshore School District

The following section is to be completed by the PARENT/GUARDIAN: (please print)

Student's Name:_____ Birth Date:_____ Sex: M ❒ F ❒
School: _____ Grade:_____
Health Care Provider (HCP) Information: Name:_____
Address:_____ Phone:_____ Fax:_____

It is absolutely necessary for my student to receive this requested service in order to attend school:

- ❒ **Catheterization**
- ❒ **Vagal Nerve Stimulator**
- ❒ **G-Tube Feeding**

G-Tubes that become dislodged or fall out: *Please be aware that school staff do not have universal training to replace G-tubes. It is the responsibility of the parent and Health Care Provider to plan for safe replacement during the school day or school activities.*

Replacement options include:

- *Parent and/or family member will come to school within the hour or time specified by the Health Care Provider.*
- *School will request and store an extra G-tube for parents to use.*
- *Parent will arrange for medical appointment and /or transportation to _____.*
- *Arrangement of a special Emergency Contact to be used if parents cannot be located.*

- ❒ **Other Procedure**: _____

⇒ I will notify the school immediately with any changes or cancellations.
⇒ I understand that a procedure will not begin until adequate training of qualified staff is completed. Procedure might be delayed or missed due to unexpected circumstances or changes in the student's schedule.
⇒ I agree to hold Northshore School District harmless from any liabilities that may occur in rendering this service except as might arise because of negligence on the part of it's employees.
⇒ **I understand that I must provide all necessary supplies and equipment to perform this service.**
⇒ I consent to exchange of information between the school and HCP.

_____ _____ _____ _____
Parent/Guardian Signature Date Home Phone Emergency Phone

The following section is to be completed by the HEALTH CARE PROVIDER:(please print)

In order for the student to attend school, it is absolutely necessary that the following be performed during school hours:

Procedure (include detailed specific instructions e.g. time/frequency of the procedure – including protocol for a disaster situation):

_____
_____
_____

Special equipment or environment recommended:_____
_____
_____

I understand that:
⇒ Services will not be started until adequate training of staff has been completed.
⇒ The student's parent/guardian will provide all necessary supplies and equipment to perform this service.
⇒ I will be responsible for monitoring the ongoing health status of this student and will notify the school of any changes in these recommendations.

Length of service period (not valid past the end of the current school year):
Start Date: _____ Discontinue Date:_____ **OR** end of school year ☐

_____ _____ _____
Health Care Provider Signature Date Phone

Return to: _____ _____ _____
School Nurse Phone # Fax #
School mailing address: