PARENT REQUEST FOR SPECIAL NURSING CARE/RELATED MEDICAL TREATMENT PROCEDURES

Name of Student _____ B.D. _____ Grade _____

Parent's Name _____ School _____

I, _____, parent/guardian of _____ request that the following service be performed for my child by district personnel of Issaquah School District. The procedure is not one that by law may only be performed by a physician. It is my understanding that this service will be performed by non-medical personnel. It is deemed absolutely necessary that this procedure be performed during school hours to enable my child to stay in school.

Service desired: _____

_____

_____

_____

_____

I have obtained detailed written instructions from Dr. _____, the physician who recommended this service. You have my permission to communicate freely with this physician in order to make arrangements for care and supervision of my child.

I will provide the school with any necessary equipment or supplies needed for this related medical procedure.

I understand service will not be started until these orders are on file in my child's school and adequate training of staff has been completed.

As parent and/or guardian of the above-named child, and on behalf of the above named minor, I agree to hold Issaquah School District No. 411 and its personnel harmless from any liabilities, to the maximum extent permitted by law, ~~it~~ **which** may incur from the performance by district personnel of the above-described service.

Date _____ Parent's Signature _____

Address _____

White: School
Yellow: Physician
Pink: Parent

City _____ Zip _____

Telephone number (_____) _____

Formerly: Policy No. 3418 F1