Edina Public Schools
Authorization for Administration of Special Health Care Procedures
(Such as gastrostomy feedings, suctioning, catheterization)

Student:_____Birthdate:_____Grade:____ School:_____

Parents/guardians asking school staff to do specialized health care procedures must provide written permission each school year that has been signed by the child's licensed health care provider and the parent/guardian.

Physician / licensed prescriber's Order for Administration of Health Care Procedure by School Personnel

Treatment Procedure	Instructions	Time / or interval to be done	Route	Amount if applicable	Medical Condition ICD-10-CM

Physician/licensed prescriber signature (required): **Date:**

Print Name of Prescriber **Clinic Name**

Phone: **Fax:**

****Authorizations expire at the end of the school year or following the summer school session.

Parent/ Guardian Authorization **NOTE**: Supplies for the procedure(s) are provided from home.

1. I request that the above health care procedure(s) be done during school hours as ordered by my child's physician/licensed prescriber.
2. I request that the procedures be given on field trips as prescribed. _____ Yes _____ No
3. I will notify the school if procedure(s) is stopped.
4. I give permission for the procedure(s) to be given by school personnel as delegated, trained, and supervised by the school nurse.
5. Legally I may refuse to sign the authorization for Special Health Care Procedures. If I refuse to sign, we will not be able to administer the procedure(s).
6. This consent may be revoked at any time by sending a written notice to the licensed school nurse.

_____ _____
Parent/Guardian Signature Date

Permission for Release of Information

1. I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition/s and the action of the medication/s in order to provide for my child's health and safety needs at school.
2. I give permission for the school nurse to contact my child's physician/licensed prescriber with questions about the above listed procedure(s) or medical condition (s) related to the procedure(s).
3. I give permission for the physician/licensed prescriber to release information related to the above procedure(s) and medical condition/s to the licensed school nurse.

_____ _____
Parent/Guardian Signature Date