Boone County Schools

School Health Services Department

Health Related Services Consent

Plan Date: _____

Student Name: _____ Date of Birth: _____ Grade: _____

Type of procedure: _____

Reason for procedure: _____

My signature below indicates, I understand that a RN/LPN or trained unlicensed personnel (per 201 KAR 20:400) will perform the procedure according to the specified physician's recommendation.

Orders (include instructions and schedule)
_____
_____
_____
_____
_____
_____
Precautions
_____
_____
_____
_____

Physician Name: _____ Physician Phone Number: _____

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____

School Nurse Use Only		
School staff trained:	Date:	Nurse Signature:
		Date:
		Notes:

Revised: Feb. 2019 SLW