FERNDALE SCHOOL DISTRICT NO. 502
Ferndale, WA 98248

Treatment Order Form

Student Name: _____ Birth Date: _____
School: _____ Grade: _____
Teacher(s): _____

This portion of the form is to be completed by the health care provider.

General or Medication Treatment
Authorization for (Type of treatment): _____
Time(s): _____
Medication needed for treatment: _____
Route: _____; Dose per treatment: _____
Instructions: _____
_____

Gastrostomy Tube Feeding
Time(s) _____Amount: _____Type: _____
☐Oral ☐Foods ☐Fluids allowed: List _____
☐Nothing by mouth
☐Directions for tube replacement: Type: _____Size:_____ Balloon volume/type: _____
Instructions: _____
*Slip tip syringe and lubricant must be provided if MicKey gastrostomy tube is used.

Bladder or other Catheterization
☐ Daily ☐ Needed even on early release day ☐Disaster planning only
☐Sterile ☐Modified Sterile ☐Clean Intermittent
Time(s): _____
Instructions: _____
_____

I request and authorize that the above named student be provided with the treatment listed above in accordance with the instructions indicated starting _____(date) and ending _____(date). It is understood that these services will be provided only during school hours or during such time that the student is under the supervision of school officials. It is also understood that non-licensed school staff, in accordance with state laws for nursing delegation, may provide this treatment. This order must be **renewed annually.**

_____ _____
Date of Signature Health Care Provider Signature

_____ _____
Telephone Number Health Care Provider Name (Print or type)

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This portion of the form is to be completed by the parent/guardian.
I certify that I am the parent, legal guardian, or other person in legal control of the above identified child and request and authorize the school to provide the treatment listed above to my child in accordance with the doctors instructions and orders for the period beginning _____through _____(not to exceed one school year). I understand that this treatment may be provided to my child by **non-licensed** school staff, in accordance with state nursing laws.

Parent signature: _____Date: _____