

REQUEST FOR SPECIAL NURSING CARE/MEDICAL TREATMENT
Bethel School District

Student Name: _____ Birthdate: _____

School: _____ Grade: _____

I request that the following service be performed for my child by Bethel School District personnel. It is my understanding that this service may 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.

I have obtained detailed written instructions from the health care provider listed below who recommended this service. You have my permission to communicate freely with this health care provider in order to make arrangements for the care and supervision of my child. I understand service will not be started until this health care provider's orders are on file in my child's school and adequate training of staff has been completed.

_____ Parent Signature	_____ Date
_____ Telephone Number	_____ Address

HEALTH CARE PROVIDER ORDERS

_____ Health Care Provider (Print)	_____ Health Care Provider Signature
_____ Date	_____ Telephone Number
_____ Address	

In order for this student to attend school, it is absolutely necessary that the following services be performed during school hours. *(Include specific instructions.)*

Special equipment or environment recommended: _____

I understand services will not be started until these orders are on file in the child's school and adequate training of staff has been completed. If needed, I am willing to participate in specific training. I understand that the child's parents will provide all necessary supplies and equipment to perform this service. I understand that this request will not be valid for any period greater than one year or past the end of the current school year whichever comes first.

Length of Period			
From:		To:	

I understand that I may be called by school personnel regarding the above recommendations and that I will be responsible for monitoring the ongoing health status of this patient.