

AUTHORIZATION FOR TREATMENT AT SCHOOL

Student _____ Birthdate _____ School _____

This portion of the form is to be completed by the Health Care Provider

Oral Intake

- Foods Instructions: _____
- Fluids add thickening agent to _____ consistency. Instructions _____
- Oral nutritional supplement. Product and instructions _____
- Nothing by mouth

Gastrostomy tube feeding **GJ tube feeding (feeding through J)**

Product _____ amount _____ time(s) _____

Feeding instructions _____

Gastrostomy tube re-insertion

Type _____ size _____ balloon volume/type _____

Replacement instructions _____

➡ Slip tip syringe and lubricant must be provided if Mic-Key gastrostomy tube is used.

I request and authorize that the above named student be provided with the treatment listed above in accordance with the instructions indicated. I certify in accordance with RCW 28A.210.260 there exists a valid health reason which makes administration of such medication advisable during the hours when school is in session or the hours in which the student is under the supervision of school officials. I understand that this treatment will be provided during such time that the student is under the supervision of school staff and that non-licensed school staff, in accordance with state laws for nursing delegation, may provide this treatment. This order must be **renewed each school year.**

Length of prescription: current school year (including summer school program) Other _____

Licensed Health Care Provider Signature

Date

LHCP printed name

Telephone number

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.

I request and authorize the school to provide the treatment listed above to my child in accordance with the Health Care Providers instructions. I understand that this treatment will be provided during such time that the student is under the supervision of school staff and that non-licensed school staff, in accordance with state laws for nursing delegation, may provide this treatment. This order must be **renewed each school year.**

Parent/guardian signature _____ Date _____ Telephone number _____