FERNDALE SCHOOL DISTRICT
Ferndale, WA 98248

AUTHORIZATION FOR TREATMENT AT SCHOOL

Student_______________________________________Birthdate__________________
School_______________________________________

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

Suctioning:

☐ Oral (Mouth) ☐ Nasal ☐ Tracheal: ☐ Other (List): ____
Instruction: ____
Suction Tubing: Size __________ ☐ Bulb Syringe
☐ Reuse with the following requirements:____
Technique: ☐ Sterile ☐ Clean ☐ Other: ____
Instructions: ____

Bladder or Other catheterization

☐ daily ☐ disaster planning only ☐ clean intermittent ☐ assisted self-cath ☐ independent
Time(s) ____
Instruction: ____
☐ List: ____
____

Other Treatments Required for school attendance (Oxygen and Feeding use specific treatment forms)
☐ Diagnosis for the abovenamed treatment: ____
☐ Instructions: ____
☐ _______________ ☐ ________________ ☐ ☐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. 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________________