Darlington County School District
Authorization for Prescribed Treatment

This form must be completed fully in order for schools to perform medical procedures. A separate form is required for each procedure. A new authorization form must be completed each school year and if there is any change with procedure. All equipment/supplies must be provided by parent/guardian.

Student Name:_________________________________ Date of Birth:_____________

School:_________________________ Grade:_______ School Year:___________

To Be Completed by Licensed Prescriber

Diagnosis/Condition:____________________________ ICD-10 Code:___________

Medical Treatment/Procedure:____

Time/Frequency:____

If PRN, for what symptoms:____

Precautions, adverse reactions, detailed instructions or criteria to contact prescriber:

____

____

Student is allowed to perform treatment/procedure: No ×Self ×With Assistance

Licensed Prescriber Signature:____________________________ Date:____________

Licensed Prescriber Name(print):__________________________ Phone:___________

Parent/Guardian Authorization

I give permission for the above named procedure/treatment to be performed by the school nurse or trained personnel. I consent to communication between the school nurse/administrator and health care provider. I agree that Darlington County School District and its employees shall incur no liability and be held harmless against any claims of injury related to the performance of prescribed procedure/treatment. I will notify the school nurse if my child’s health status or procedure/treatment changes.

Parent/Guardian Signature:_____________________________ Date:______________

Parent/Guardian Name (print):___________________________ Phone:_____________

5/2021