MINNEAPOLIS PUBLIC SCHOOLS
Urban Education. Global Citizens.

Minneapolis Public Schools
Health Related Services

Date:
Entered in Disc. _____
Scanned to Discovery _____

Authorization for Administration of Special Health Care Procedures

(Such as tracheostomy care, gastrostomy feedings, bladder catheterization, etc.)

Parents/guardians requesting specialized health care procedures to be administered by school staff are required to provide annual written permission signed by the parent/guardian **and** the child's health care provider.

Student: _____ BD: _____ ID#: _____

School: _____ School year: _____ Grade/Rm: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Physician/licensed prescriber's order for Administration of Health Care Procedures by School Personnel

*Medical Diagnosis & ICD-10-CM Code **MUST** be completed by Physician/Licensed Prescriber*

Medical Diagnosis	ICD-10-CM Code	Treatment/ Procedure(s)	Instructions	Time or Interval to be done	Amount if Applicable	Precautions/ Adverse Reactions
1.						
2.						

Other considerations/directions: _____

Start date: _____ Stop date: _____

(All authorizations expire at the end of the school year.)

_____ _____ _____
Signature of Physician/Licensed Prescriber | Print name of Physician/Licensed Prescriber | Date

_____ _____ _____
Clinic address | Phone | Fax

TO BE COMPLETED BY PARENT/GUARDIAN

Parent/Guardian Authorization

1. I request that the above health care procedure(s) be done during school hours as ordered by my child's physician/licensed prescriber. I also request the health care procedure(s) be given on field trips, as prescribed.
2. I will notify the school of any change in the procedure(s), (i.e., change in time or amount, procedure is stopped, etc.).
3. I give permission for the procedure(s) to be done by school personnel as delegated, trained, and supervised by the school nurse.
4. Legally, I may refuse to sign for the treatment. If I refuse to sign, we will not be able to provide the treatment at school.
5. This consent may be revoked at any time, by sending a written notice to the licensed school nurse.

NOTE: Supplies for procedure(s) are to be provided from home.

Permission for Release of Information

6. I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition(s) and the prescribed procedure(s).
7. I give permission for the school nurse to consult with my child's physician/licensed prescriber about any questions regarding the prescribed procedure(s) or medical condition(s) related to the procedure(s).
8. I give permission for the physician/licensed prescriber to release information related to the above procedure(s) and medical condition(s) to the licensed school nurse.

_____ _____ _____
Parent/Guardian Signature | Date | Relationship to Student

RETURN TO: _____ Phone: _____ Fax:_____
RN, Licensed School Nurse

R/R 6/2015