Farmington Public School District

AUTHORIZATION FOR MEDICAL PROCEDURE

Please complete this form, sign and return it to student's school if you wish to authorize District staff to perform a specific medical procedure during school hours. Please keep in mind that the staff performing this will not be healthcare professionals and you must provide any special training needed for our staff to perform it correctly. By signing this, you are acknowledging and agreeing that this procedure can be done at Farmington Public Schools at the days, times and locations agreed upon below by non-medically trained lay-persons and without expectation of trained medical oversight. You also agree to inform us if changes in the student's medical condition warrant a change in how care is provided or a change in the qualifications required of the person providing that care.

PHYSICIAN PLEASE COMPLETE:

Student's Name _____ Location/Building _____

Medical diagnosis and reason for procedure _____

Type of Procedure Day(s) and Time(s) _____

- Oxygen Administration
  Frequency _____ Rate of Delivery _____
- Oral Suction _____
- Tracheal Suction _____
- Tube Feeding: G-Tube _____ J-Tube _____ Time(s) _____

  Formula _____Amount _____

  Pump Rate of Delivery _____

  Gravity Drip _____ Bolus _____
- Urinary Catheterization: Catheter Size _____ Type _____

  Frequency/Time _____
- Other Procedure _____

_____

Physician Signature _____ Date _____
Print Name _____ Phone _____
Address _____
City/State _____ Zip _____

Parent/Guardian Signature _____ Date _____