Franklin County Schools
Physician and Parent Authorization For Specialized Health Care Procedure

Return completed form to the school nurse.

Name of Student: ______________________________________ Birthdate: ____________________

Address: ____ Phone: ____________________

1. Please describe the physical condition/medical diagnosis for which the specialized health care procedure is to be performed: ____
____
____

2. Name of Procedure (e.g., catheterization, gastrostomy feeding; suctioning) to be provided:
____

3. Precautions, possible untoward reactions, and interventions to take: ____________________
____
____

4. Time schedule and/or indication for the procedure: __________________________________
____

5. The procedure is to be continued as above until: ______________________________________
Date

6. Please list any additional information or instructions regarding the student's condition that may assist the nurse in delegating and training unlicensed personnel to perform this procedure:
____
____
____
____

7. Student is competent to perform procedure ☐ **Yes** ☐ **No** (needs staff assistance)

____ ____________________
Physician's Printed Name / Signature **Date**

____ ____________________
Address **Phone**

(parent to complete the back of this form)

Parent Consent Form for Health Care Procedure in the School Setting

Student Name: ________________________________ **Date of Birth:** __________

School Name: ________________________________ **School Year:** __________

My student requires school staff to perform and/or assist with the following medical procedure(s) at school:

____

__________ **Initial** I acknowledge that the above procedure and any other medical care performed by school staff, including the school nurse, may require the release and exchange of personally identifiable information contained in my student's education records between FCS and my student's physician. I authorize the release and exchange of any and all health related information, in whatever form necessary to facilitate the treatment and medical care of my student at school between FCS and the physician named below. I acknowledge that this constitutes my written consent to the release of confidential student records and/or confidential personally identifiable information that are protected under the federal Family Educational and Privacy Rights Act (FERPA) and state law governing the confidentiality of student records and personally identifiable information contained in such records.

____________________________ ____________________________

Physician's Name **Physician's Phone Number**

__________ **Initial** I understand that I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing. Absent such notice, this authorization expires one calendar year from the date signed.

__________ **Initial** The school nurse has my permission to teach designated school staff to perform the procedure(s) listed above if my student is unable to perform the procedure without assistance.

__________ **Initial** I understand that the school nurse is not on duty before or after school hours. If my child participates in any FCS before/after school programs, activities, or sports, I will assume responsibility for informing the program/activity director or coach of my child's medical condition and any care that may be necessary during their participation.

__________ **Initial** I agree to furnish all needed supplies and equipment for the above listed procedure. As purchaser of the equipment and supplies for the procedure(s), I will be responsible for ongoing control checks/calibration/repairs, as specified by the manufacturer's warranty.

__________ **Initial** I understand that I will be provided a copy of this authorization upon my request.

__________ **Initial** I am the legal parent/guardian of the student listed above.

I have read and understand the information in this authorization form.

Signature of the Legal Parent/Guardian:	
Name of Parent/Guardian (please print):	**Date:**
Address:	**Telephone Number:**