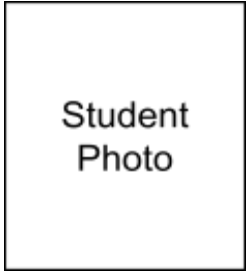




Fairbanks North Star Borough School District
Other Nursing Care Plan



LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
SCHOOL		GRADE	STUDENT ID

Please see specific Care Plans for Allergy/Anaphylaxis, Asthma, Diabetes, Enteral Feeding, Seizures, or Urinary Catheter at <https://www.k12northstar.org/departments/nursing-services/school-health-office-resource-page/forms>. This form is used for all other authorizations of specialized nursing care.

MEDICAL PROVIDER AUTHORIZATION

MEDICAL DIAGNOSIS: _____

EQUIPMENT: _____

ORDERS *(please include description, time, frequency, and duration, etc)*

MEDICAL PROVIDER NAME/TITLE	PHONE
MEDICAL PROVIDER SIGNATURE	DATE

THESE ORDERS EXPIRE AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL



Fairbanks North Star Borough School District
Other Nursing Care Plan

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
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PARENT/GUARDIAN AGREEMENT AND AUTHORIZATION

I request that nursing care, as outlined on this plan by my child’s licensed healthcare practitioner, be provided during school hours. I will supply all necessary medication and supplies and will notify the school in writing of any changes to the care plan. I understand and authorize trained school personnel, under the delegation and supervision of a registered nurse, to provide this care in accordance with 12 AAC 44.950–44.975 of the Alaska Administrative Code.

Employees and agents of the Fairbanks North Star Borough School District (“FNSBSD”) strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless FNSBSD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including for NEGLIGENCE. I will notify FNSBSD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the healthcare practitioner listed on this plan and FNSBSD as part of the provision of my child’s care. I agree for the Health Office to share health information with FNSBSD staff on a need-to-know basis for my child’s safety and to foster academic success.

I understand that ANY remaining care supplies will be disposed of at the end of the school year, unless I pick up the remaining supplies by the last school day, as indicated on the FNSBSD school year calendar.

THIS CARE PLAN EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL.

<i>PARENT/GUARDIAN NAME</i>	<i>RELATIONSHIP TO STUDENT</i>	<i>PHONE NUMBER</i>
<i>PARENT/GUARDIAN SIGNATURE</i>		<i>DATE</i>

NURSE PLAN REVIEW

I have reviewed this nursing care plan for accuracy and ensure that all required fields and signatures are completed before providing care to a student. I approve of the agreement arranged between the healthcare practitioner, parent/guardian, Health Office, and student for the management of the student’s health needs. I will conduct training with school staff, as needed, to ensure the safety and wellbeing of the student in the school setting.

<i>NURSE NAME</i>	
<i>NURSE SIGNATURE</i>	<i>DATE</i>