School Year: _____

PARENT CONSENT AND PHYSICIAN ORDER FOR SPECIALIZED NURSING INTERVENTION OR TREATMENT
HEALTH SERVICES

PARENT/GUARDIAN CONSENT FOR SPECIALIZED NURSING INTERVENTION OR TREATMENT

I give my permission for the school nurse or a staff member trained by the school nurse to perform the following specialized nursing intervention or treatment prescribed by_____(Physician or Licensed Care Provider) and to contact the Physician regarding any treatment orders, the implementation of the orders, and the outcomes from these treatments. I request that the school continue the intervention or treatment for the duration of the school year or until notified by me or the Physician to change or discontinue. Notice of change must be received in writing. Orders must be renewed annually.

_____ _____

Parent/guardian signature Date

PHYSICIAN ORDER FOR SPECIALIZED NURSING INTERVENTION OR TREATMENT

Your assistance is necessary for appropriate health management in the school setting. Please provide detailed orders for any PPS needed at school for the 20___-20 ___school year.

Name of student: _____ Birth date: _____
Condition to be treated: _____
Specialized nursing intervention or treatment: _____
_____
Prescribed treatment protocol: _____
_____
_____
_____
Time schedule and/or indications: _____
_____
Precautions, possible side effects, and recommended interventions: _____
_____

I am aware that this treatment may be delegated by the school registered nurse to an unlicensed staff member who is trained and supervised by the nurse.

Physician name (please print): _____
Address: _____ Phone: _____
Physician Signature: _____ Date:_____
If completed by a nurse practitioner, please indicate the physician in collaborative practice.
Please return by mail or fax to the address or fax # below:
School Address: _____ FAX: _____

12110 Clayton Rd. * Town & Country, Missouri 63131 * 989-8100