AUTHORIZATION FOR MEDICAL TREATMENT REQUIRED AT SCHOOL

Each procedure must be prescribed on separate forms. In order that each student will be able to participate in educational programs, School Districts require a physician's written order and parent/guardian authorization for medical procedure to be done in school. It is expected that all medical procedures will be performed at home unless absolutely necessary. Medical procedures will be scheduled, by the school, in coordination with the student's educational program.

Date: _____

Name of Child _____ Date of Birth _____

Condition for which specific medical treatment is to be done: _____

Name of Specific Medical Procedure _____

If Specific Medical Procedure is a tube feeding, please indicate type of formula and amount to be given at each feeding: *_____

Consideration for scheduling of treatment: (i.e., prior to meals.) _____

Precautions, possible untoward reaction, interventions: _____

_____

_____

Reactions to be reported to the physician: Y ___ N ___ Describe _____

Length of time Specific Medical Procedure is to be done as above: _____

From _____ To _____ If no time limit is specified, it will expire in one (1) year.
Date *Date*

Physician's Signature _____ Telephone Number: _____

National Provider Identification number (Medicaid Required): NPI# _____

Address: _____

*** no more than 1/3 of the total daily caloric intake of the student may be given at school**

Authorization of Parent/Guardian

I hereby request that school personnel provide my child, _____the Specific
student's name
Medical Procedure as ordered above by the physician and will not hold the Board of Education or its personnel responsible for complications related to this procedure.

_____ _____
Signature of Parent/Guardian Date