

## Medically Necessary Treatment in School Setting Parent/Provider Agreement

This **Parent/Provider Agreement** and the **Physician/Health Care Provider Statement** must be completed, signed, and returned to the designated Team Lead before your student can receive medically necessary treatment in the school setting. This agreement and associated forms also must be completed, signed, and submitted prior to the start of **each subsequent school year in which your student will receive medically necessary treatment at school**. Please maintain copies of these forms for your records.

Student's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Grade \_\_\_\_\_

Mapleton School of Enrollment \_\_\_\_\_

School Lead: \_\_\_\_\_

### **Family Information:**

Parent/Guardian Name(s) \_\_\_\_\_

Home Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Phone #2 \_\_\_\_\_

### **Private Provider Information:**

Provider name \_\_\_\_\_ Practice name \_\_\_\_\_

Practice Address \_\_\_\_\_

Phone Number \_\_\_\_\_ CO License # \_\_\_\_\_

### **Plan for Medically Necessary Treatment in the School Setting:**

Describe nature/purpose of treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ will receive \_\_\_\_\_ sessions per \_\_\_\_\_ lasting approximately \_\_\_\_\_ minutes each

in the following location: \_\_\_\_\_. The provider will work with the

student on the following days: \_\_\_\_\_ at the following times: \_\_\_\_\_.

Add other pertinent information here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE READ AND INITIAL THE INFORMATION BELOW**

| Parent/<br>Guardian<br>Initials | Provider<br>Initials | In consideration for the agreement of Mapleton Public School District – Adams 1 (“District”) to allow the private provider listed above (“Provider”) to provide medically necessary treatment to the student listed above during the school day and on District grounds, Parents/Guardians and the Provider agree as follows:                                                                                                                                                                                                                                       |
|---------------------------------|----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                 |                      | I understand and agree that the private provider listed above and any individuals employed by the private provider to treat the student at school must provide proof of Colorado licensure or other appropriate authorization before they can treat the student at school.                                                                                                                                                                                                                                                                                          |
|                                 |                      | I understand and agree that the private provider listed above and any individuals employed by the private provider to treat the student at school are required to submit to a background check, including fingerprinting, before they can treat the student at school.                                                                                                                                                                                                                                                                                              |
|                                 |                      | I understand and agree that the private provider listed above and any individuals employed by the private provider to treat the student at school will be supervised by their employing agency and not the District.                                                                                                                                                                                                                                                                                                                                                |
|                                 |                      | I understand and agree that the private provider will work with the student in public areas and shall not be alone behind closed doors with the student without a District employee present.                                                                                                                                                                                                                                                                                                                                                                        |
|                                 |                      | I understand and agree that the private provider listed above and any individuals employed by the private provider to treat the student at school may access the student's education records only with written parental consent and in accordance with the Family Educational Rights and Privacy Act (FERPA).                                                                                                                                                                                                                                                       |
|                                 |                      | I understand and agree that the private provider listed above will maintain and provide the District with proof of General Liability, Auto Liability, and Professional Liability Insurance consistent with District requirements prior to the provision of any treatment for the student at school. I further understand and agree that the insurance held by the private provider will provide complete coverage for any occurrence arising from the private provider's or private provider's employees' acts or omissions in providing treatment for the student. |
|                                 |                      | I understand and agree that I waive liability of any and all claims against the District for any negligence, intentional conduct, malpractice, or other misconduct on the part of the Provider, including claims arising from the conduct of the Provider under the Claire Davis School Safety Act, C.R.S. 24-10-106.3 and C.R.S. 13-20-1201 et seq., Actions for Sexual Misconduct Against Minors.                                                                                                                                                                 |
|                                 |                      | I understand and agree to waive any and all claims for relief related to the provision of treatment for the student in the school setting, including any and all claims for relief concerning injuries to the private provider and/or any individuals employed by the private provider caused by the student and/or any other student at school.                                                                                                                                                                                                                    |
|                                 |                      | I understand and agree to indemnify, defend and hold harmless the District and its officers, agents, employees, and representatives against any and all claims incurred as a result of any act or omission by the private provider and/or any individuals employed by the private provider to treat the student at school.                                                                                                                                                                                                                                          |
|                                 |                      | I understand and agree to avoid disruption to the learning environment for all students, to avoid disruption to the student's and other students' access to educational services, and to maintain the integrity of all students' instructional programs. I understand and agree that the integrity of the student's instructional programming, both in general and special education settings, must be maintained at all times and that any disruption to the student's or other students' learning may result in the discontinuation of this agreement.            |
|                                 |                      | I understand and agree that the private provider shall maintain confidentiality of school matters. I understand that the private provider shall not share criticisms of teachers/staff with students, parents/guardians, or other persons. Valid concerns shall be addressed privately with the building administrator and/or program director/assistant director.                                                                                                                                                                                                  |
|                                 |                      | I understand and agree that scheduling of treatment must be done in partnership with the building administrator and that the school has sole discretion to deny a visit, or to reschedule or modify a visit, if the visit will interfere with the school's necessary activities, the schedule of school staff, or other scheduling priorities. Except in an emergency, the school will endeavor to give the private provider and the family two weeks' advance notice of any need for rescheduling or modification of an existing visit.                            |
|                                 |                      | I understand and agree that the student's parent or legal guardian will be solely responsible for compensating the private provider for any treatment provided to the student, and the District will have no financial obligation to the private provider for fees, expenses, or any other associated costs. If the private provider offers opinions,                                                                                                                                                                                                               |

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|--|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  |  | suggestions, observations, advice, or consultation to/for District staff, I understand and agree that the District will not be obligated to pay any associated fee or charge.                                                                                                                                                                                                                                                                                                                                                                                                     |
|  |  | I understand and agree that the private provider and any individuals employed by the private provider must follow all applicable provisions of state and federal law and district policy any time they are on District premises. I further understand and agree that permission to provide medically necessary treatment at school may be limited or revoked if the private provider or employee thereof violates this agreement or otherwise engages in action that violates District policy and/or federal or state law.                                                        |
|  |  | I understand and agree that the District will not exercise supervisory control over the content or nature of the private provider's treatment of the student. However, if requested, I agree that the District is entitled to advance discussion and review of the content and nature of the treatment in order to coordinate such treatment with other classroom and school activities.                                                                                                                                                                                          |
|  |  | I understand and agree that for medically necessary treatment to continue in the school setting, the student must be receiving on-going support from the private provider, a release for the school to confer with the private provider must be in place, and that an updated Physician/Health Care Provider Statement must be provided prior to the start of each school year the student will receive treatment at school. I understand that without the updated Physician/Health Care Provider Statement, the private provider cannot provide treatment in the school setting. |
|  |  | I understand and agree to waive any claims for a Free Appropriate Public Education under the Individuals with Disabilities Act ("IDEA") to the extent that the rendering of services by the private provider interferes or restricts any required educational or related services under the Student's current IEP/504.                                                                                                                                                                                                                                                            |
|  |  | I understand and agree that the District may remove its consent to allow the private provider to provide medically necessary treatment to my/our child during the school day at any time for any reason deemed sufficient by the District. The parents/guardians and/or therapist may appeal such removal of consent to the Executive Director of Integrated Services.                                                                                                                                                                                                            |

**By signing below, I acknowledge and affirm that I am entering into this agreement voluntarily. Further, each individual signing this agreement on behalf of a party asserts that he or she is legally authorized to make the agreements memorialized herein and to execute this agreement on its/his/her/their behalf.**

**Parents/Legal Guardians, on behalf of themselves and the student identified above:**

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

Printed Name: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

Printed Name: \_\_\_\_\_

**Private Provider, on behalf of the Provider and any employees thereof:**

\_\_\_\_\_  
Signature of Private Provider

\_\_\_\_\_  
Date

Printed Name: \_\_\_\_\_

**School Administrator/Team Lead:**

\_\_\_\_\_  
Signature of School Administrator/Team Lead

\_\_\_\_\_  
Date

Printed Name: \_\_\_\_\_