Naugatuck Board Of Education

Department of Health Services

# PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF SPECIALIZED HEALTH CARE PROCEDURE IN SCHOOL

Student:_____ DOB:_____
Address:_____
Medical condition for which the procedure is to be performed:_____
Name of Procedure:_____
Precautions, possible untoward reactions: _____

Time/Times procedure is to be administered:_____

For G Tube feedings:
Type of nutritional supplement:_____
Dose/Volume of feeding:_____
via:_____
flush with:_____ cc's Before:____ After:_____ Feeding provided

The procedure is to be provided From:_____ To:_____

Authorized prescriber's signature_____
Authorized prescriber's name (PRINT)_____
Date:_____Phone:_____ Fax:_____

*Use for Prescriber's Stamp*

Parent to sign:
To Whom It May Concern: I hereby give my permission for exchange of confidential information contained in the record of my child between the school nurse and my child's physician.

Parent/guardian Name:_____

Signature of Parent/Guardian:_____

From:_____ To:_____

# Naugatuck Board Of Education

## Department of Health Services

PARENT'S PERMISSION FOR THE ADMINISTRATION OF SPECIALIZED HEALTH CARE PROCEDURE IN SCHOOL

We (I), the undersigned, who are the parents/guardians of:
Name: _____Birth Date:_____
request that the following specialized health care procedure be administered to our child:
_____
We understand that a qualified designated person(s) will be performing the above mentioned health care procedure.

It is our understanding that the designated person(s) will use the procedure written into the student's IHCP, according to Connecticut Nursing Standards and the treating physician's orders. We understand that we need to provide new orders each school year.

We understand that we need to provide all supplies required for the nurse to perform the procedure ordered by the physician including:

_____ _____
_____ _____
_____ _____

We agree to come and pick up our child should they need more immediate care outside of the school setting, including but not limited to;
___reinsertion of a Gastrostomy Tube.
We understand that we will come to the school and reinsert the G Tube within 30 minutes or the school nurse will have to call 911 to transfer to the ER for reinsertion if you, the parent/guardian cannot come to the school within 30 minutes.
___Other
procedure_____
_____

Treating Physician's Name: _____
Address_____
Telephone No._____

We will notify the school immediately if the health status changes, we change physicians, or the procedure is changed or cancelled. We understand that, whenever possible, the specialized health care procedure should be provided before or after school hours.

Signature of parent/guardian:_____
Telephone number:_____
Date:_____