Valdez City Schools
PO Box 398
1112 West Klutina – Valdez, AK 99686
Telephone (907) 835-4357
Fax (907) 835-4964

OTHER NURSING CARE PLAN

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL			GRADE

Medical Diagnosis:

MEDICAL PROVIDER AUTHORIZATION
(Provider have parent/guardian sign Authorization & Agreement page 2-2)

Please see specific authorization forms for medication, enteral feeding care, tracheostomy care, and urinary catheter care. This form is used for all other authorizations of specialized nursing care. Please write your medical authorization orders below.

Other nursing care orders (please include procedure, device type, time/frequency, etc.):

LICENSED MEDICAL PROVIDER IN ALASKA (PRINTED)	TELEPHONE NUMBER
LICENSED MEDICAL PROVIDER SIGNATURE AND CREDENTIALS	DATE

Valdez City Schools
PO Box 398
1112 West Klutina – Valdez, AK 99686
Telephone (907) 835-4357
Fax (907) 835-4964

PARENT / GUARDIAN AUTHORIZATION

I request that the nursing care outlined on this plan be given to my child. **I will provide needed medications or supplies for care in school.**

Employees and agents of theValdez City School District (VCS) strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless VCS 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 VCS immediately if the medications or protocols change. I give permission for the exchange or release of health information between the medical provider listed above and VCS as part of the provision of my child's care. I agree for the nurse to share health information with VCS 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 VCS school year calendar.

PARENT / GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	TELEPHONE NUMBER
PARENT / GUARDIAN (SIGNATURE)		DATE

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 physician, parent, nurse, 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 well-being of the student in the school setting.

NURSE NAME (PRINTED)	
NURSE SIGNATURE	DATE