School Health Program

AUTHORIZATION FOR MEDICAL TREATMENT FORM

NAME: _____ DATE OF BIRTH: _____

SCHOOL: _____ GRADE: _____

TEACHER: _____

PART I: PARENT/GUARDIAN SPECIFIC MEDICAL PROCEDURE/TREATMENT AUTHORIZATION CONSENT FORM

Parent/Guardian: Please complete and sign this action.

I hereby request and authorize the School Nurse (RN, LPN, Nurse's Aide, Technician) or a trained DCPS employee to perform _____
SPECIFIC MEDICAL PROCEDURE/TREATMENT

on my child _____ as prescribed by the physician below.

I have read the information on the reverse side of this form and agree to assume responsibilities as required.

_____ _____
SIGNATURE OF PARENT/GUARDIAN RELATIONSHIP TO CHILD

_____ _____
PLEASE PRINT DATE

PART II: PHYSICIAN'S SPECIFIC MEDICAL PROCEDURE/TREATMENT AUTHORIZATION ORDER

Physician: Please complete and sign this action.

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ PHONE: _____

DIAGNOSIS: _____

SPECIFIC PROCEDURE/TREATMENT: _____

TO BEGIN ON: _____ AND END ON _____
DATE DATE

REASON FOR PROCEDURE/TREATMENT: _____

_____

PRECAUTIONS: _____

POSSIBLE ADVERSE REACTIONS: _____

_____ _____
PHYSICIAN'S SIGNATURE PLEASE PRINT

_____ _____
ADDRESS PHONE

_____
SCHOOL NURSE