Dear Parent/Guardian and Physician:

Students in need of specific medical procedures/treatments during school hours must meet the following requirements:

1. Parents/guardians must present to the principal and school nurse a signed consent and physician’s written authorization for the procedure/treatment. The physician’s authorization and parent’s consent will be maintained in the Student Health Record.

2. The parent/guardian’s signed consent and physician’s authorization must be in place before the student receives the specific medical procedure/treatment.

3. The physician’s authorization must include: the student’s name, date of birth, address, telephone number, diagnosis, name of procedure/treatment, reason for and any precautions or possible adverse reactions to the procedure/treatment that authorized personnel may expect.

4. The parent/guardian must meet at school with the principal, school nurse and other authorized school personnel to initiate the specific medical procedure/treatment.

5. Supplies to provide a specific medical procedure/treatment must be provided by the parent/guardian. All equipment and supplies that are required must remain in the school if possible.

6. Physician authorization for specific medical procedures/treatments must be renewed at the beginning of each semester and summer school if the student continues to need the procedure/treatment.

7. If any adjustments (i.e., technique, frequency, medications) are made, a new Physician Authorization and Parental Consent Form will be required.

8. All equipment and supplies kept in the school will be stored in a secured area accessible only to authorized administering personnel. Such storage will be at the risk of the parent/guardian. Children’s National Medical Center School Health Program personnel (CNMC School Nurses) and District of Columbia Public School personnel (DCPS trained persons) assume no responsibility for possible loss or damage to equipment and supplies.

9. One week after expiration of the physician’s order, the equipment and unused portions of the supplies must be collected by the parent/guardian, or they will be discarded.

10. CSS personnel and DCPS personnel assume no responsibility for non-medically prescribed procedures/treatments or those self-administered by the student.
School Health Program

AUTHORIZATION FOR MEDICAL PROCEDURE/TREATMENT

NAME: ___________________________  DOB: ___________________________

SCHOOL: ___________________________  SSN#: ___________________________

TEACHER: ___________________________  GRADE: ___________________________

PART I: PARENT/GUARDIAN 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: ___________________________  DOB: ___________________________

ADDRESS: ___________________________  PHONE: ___________________________

DIAGNOSIS: ___________________________

SPECIFIC PROCEDURE/TREATMENT: ___________________________

TO BEGIN ON: ___________________________ AND END ON ___________________________ DATE: ___________________________ DATE: ___________________________

REASON FOR PROCEDURE/TREATMENT: ___________________________

INSTRUCTIONS: ___________________________

PRECAUTIONS: ___________________________

POSSIBLE ADVERSE REACTIONS: ___________________________

PHYSICIAN’S SIGNATURE ___________________________  PLEASE PRINT ___________________________

ADDRESS: ___________________________  PHONE: ___________________________

SCHOOL NURSE ___________________________  Revised: 3/07