BARRINGTON 220
310 E. JAMES ST.
BARRINGTON, IL 60010

REQUEST FOR TREATMENT PROCEDURE DURING SCHOOL HOURS

STUDENT NAME: ____
TREATMENT (S) REQUESTED: ____

TO BE COMPLETED BY PHYSICIAN

This child, _____________________________________, is under medical care for

____ and is required to have the following

treatment (s) during school hours.

1. TREATMENT ORDER:

2. TREATMENT ORDER:

EQUIPMENT SIZE____

FREQUENCY OF TREATMENT____

DURATION OF TREATMENT____

SIDE EFFECTS / PRECAUTIONS____

TO WHAT DEGREE CAN CHILD PARTICIPATE IN TREATMENT PROCEDURE?

INDEPENDENT_____ NEEDS ASSISTANCE_____ UNABLE TO ASSIST_____

Signature of Physician: _____________________________________ Date:_______________
Printed Name of Physician
Address
Emergency telephone number
FAX number

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I, ____, give permission for my child to receive the above treatment (s) as directed by the physician. I will provide all supplies needed to do the procedure. I will notify the school in writing if the treatment is discontinued. I also understand that my signature on this form denotes permission for the school nurse and the prescribing physician to confer regarding the administration / monitoring of the above named treatment (s).

Parent or Guardian signature: _____________________________________ Date; ___________