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 TREATIMENT ____

SIDE EFFECTS / PRECAUTIONS ____

TO WHATE 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 treatment(s).

Parent or Guardian signature:____________________________________ Date: _____________

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