

Authorization for Medical Treatment During School Hours

Complete ONE form for EACH treatment and attach separate orders from prescribing provider if available.

Student Name: _____ Date of Birth: ___ / ___ / ___

School Name: _____ School Year: _____

Treatment Description including Frequency/Time:

Reason for treatment (medical diagnosis):

Start Date: ___ / ___ / ___ End Date: ___ / ___ / ___

Name of Health Care Provider: _____

Office Phone Number: _____ Fax Number: _____

Signature of Health Care Provider with prescriptive authority if separate signed orders are not provided:

_____ Date: ___ / ___ / ___

I understand that whenever possible, medical treatment should be provided outside of normal school hours. I also understand that it is my responsibility to furnish any supplies necessary for the treatment clearly identified with my child's name. Any changes will require an additional signed and completed 'Authorization for Medical Treatment' form.

I give my permission for the appropriate school staff to contact the prescribing physician regarding this treatment, to request information from the provider or provide any information to the provider that relates to the treatment prescribed. I understand that medical treatment is provided solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by Academy District 20, the undersigned parent or guardian agrees to release Academy District 20 and its personnel from any legal claim which he, she or their child may now have or may hereafter have arising out of side effects or other medical consequences of the prescribed treatment. I hereby give my permission for the student named above to receive medical treatment at school as ordered.

Name of Parent/Guardian: _____ Date: ___ / ___ / ___

Contact phone numbers (home, cell, other): _____

Parent/Guardian Signature: _____