Authorization for Performance of Treatment/Procedure

HAND IN HAND
CHRISTIAN MONTESSORI

Child's Name _____ DOB: _____ Classroom: _____School Year: _____

Physician/Licensed Prescriber Order for Performance of Treatment by School Staff

(TO BE COMPLETED BY HEALTH CARE PROVIDER)

Treatment Start Date: _____ Treatment End Date: _____

(All authorizations expire at the end of the school year or following the summer school session.)

Treatment	Medical Indication	Frequency/Time	Special Instructions

_____ _____ _____

Physician/Licensed Prescriber Signature | Print Name of Physician/Licensed Prescriber | Date

_____ _____ _____

Clinic Name & Address | Phone # | Fax #

Parent/Guardian Treatment/Procedure Authorization & Permission for Release of Information

(TO BE COMPLETED BY PARENT/GUARDIAN)

1. I request that the above treatment/procedure be performed during school hours as ordered by the student's physician/licensed prescriber. I also request that the treatment/procedure be performed on field trips, as prescribed.
2. I give permission for the treatment/procedure to be performed by designated staff as delegated, trained, and supervised by the school nurse/health consultant.
3. I will notify the school in writing of any changes that are made to treatment/procedure and/or regimen (i.e. frequency or time change).
4. I give permission for the school health staff to communicate, as needed, with school staff about my child's medical condition and the necessity of the treatment/procedure.
5. I give permission for the school health staff to consult with my child's physician/licensed prescriber about any questions regarding the listed treatment procedure/procedure or medical condition(s) being addressed by the treatment.
6. I give permission for the physician/licensed prescriber to release information related to the above treatment/procedure and medical condition(s) to the school health staff.

_____ _____ _____

Parent/Guardian Signature | Date | Phone #

Please submit this completed form to the school health office.

Information Regarding the Performance of Treatment/Procedure at School

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1. Parents/guardians asking school staff to perform a medical treatment/procedure must provide written permission every school year that has been signed by the parent/guardian.

2. The student's physician/licensed prescriber much also provide written authorization for all potentially invasive treatments/procedures.

3. Parents must notify the school in writing if a treatment/procedure is discontinued.

4. A new treatment/procedure consent form is required:
    a) When the frequency or time of administration is changed
    b) At the beginning of each school year
    c) If a discontinued treatment/procedure is restarted

We look forward to serving your family! Please reach out to healthoffice@hihcm.org with any questions or special considerations.