Authorization for Administration of Treatment

_____ is under my medical care and requires the following treatment during school hours. In the absence of the school nurse, I authorize designated school staff to perform the following treatment if allowed by law:

To be completed by the Doctor:

Treatment order: _____

Equipment: _____

Frequency of treatment: _____

Side effects/Precautions: _____

Physician's name: _____

Physician's address: _____

Physician's telephone: _____

Physician's Signature: _____

To be completed by the parent/guardian:

I, _____, give permission for my child to receive the above treatment(s) as directed by the physician. I will provide all supplies needed for the treatment/procedure. I will notify the school in writing if the treatment is discontinued. I understand that in the nurse's absence designated staff will assist in the above treatment if allowed per state law.

_____

Parent/Guardian signature Date