SEAMAN UNIFIED SCHOOL DISTRICT #345
REQUEST FOR TREATMENT/MEDICAL PROCEDURE AT SCHOOL

TO BE COMPLETED BY MEDICAL PROVIDER

Student Name ________________________ Date of Birth ____________ Grade ____________

Physical condition(s) for which treatment/medical procedure is needed

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Type of Treatment/Medical Procedure

____

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Frequency of Treatment/Medical Procedure ____

For Tube Feedings Only: Type of Formula _______________ Amt ______________________

____ ____________________

Physician/Health Care Provider Name Phone Number

____ ____________________

Physician/Health Care Provider Signature Date

TO BE COMPLETED BY PARENT/GUARDIAN

I understand I am requesting a Treatment/Medical Procedure to be performed for my child at school. I understand a qualified individual will perform such treatment/medical procedure under the direction of the Seaman School District #345 Registered Nurse. I understand that any and all changes that occur during the school year require a signed authorization from the health care provider. I understand that to properly perform this treatment/medical procedure, the Seaman School District #345 Registered Nurse may require clarification from the health care provider to assist them in the treatment activities that I have requested. I understand that the health care provider may disclose protected health information in consultation with the Seaman School District #345 Registered Nurse.

____ _____________________

Parent/Guardian Signature Date

TO BE COMPLETED BY SCHOOL NURSE

Can Treatment/Medical Procedure be Delegated to a non-licensed personnel? ____Yes ____No

If Treatment/Medical Procedure is Delegated documentation of Delegated Task has been completed: _____ Yes _____ No

____ _____________________

School Nurse Signature Date

8/06