- - - -L - •

					Date of Birth:	
* Home Address:						
*School:		*Gro	ide:	*Cla	*Class:	
School Phone #:			Schoo	School Fax#:		
Allergies:						
Diagnosis:						
DICATION	*DOSAGE	*ROUTE	*FREQUENCY		SPECIFIC TIMES	*SPECIAL INSTRUCTIONS/SI EFFECTS
*Prescriber's Name	(Printed)		*P	rescriber's	s Signature	
*Prescriber's Name *Prescriber's Telepf		bers			s Signature ninistration to B	Begin
	none & Fax Num	bers	*D	pate of Adn	-	
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*Prescriber's Teleph Prescriber's Office A Student's Name: I grant the board, or persection of the section of the se	Address (TO BE (TO BE (b) designated by th thool day, including er prescriber to self- o self-administer the that my child is ur to perform the adm e supplied in the orig providing one for hor	PARENTAL PEI COMPLETED BY THE e board, permission when he/she is av cadminister their n eir medication at s hable to self-admin hinistration of the r ginal container. As me and one for scl	*D RMISSION F STUDENT'S P. Da on to assist o vay from sch hedication fa school and w nister their m medication. k the pharma hool.	Pate of Adm Pate of Adm OR MEDICA ARENT / GUAF ARENT / GUAF AR	ninistration to B ninistration to C TION RDIAN) :Grac e administration of e for official school ev re, diabetes care, or away from school p give permission for t	cease de: each medication to or rents. If my child has anaphylaxis, I grant property for official he board, or person

Parent / Guardian Name (Printed)

Signature of Parent / Guardian

Date Signed

Best Number(s) to be reached



AUTHORIZATION FOR TREATMENT

		*Date of Birth:
* Home Address: *School:	*Crado	
*School:	Glude	*Class:
School Phone #:	Schoo	l Fax#:
Allergies:		
Diagnosis:		

TREATMENTS DURING SCHOOL HOURS

		MEDS / FEEDING	FREQUENCY	RATE /
PROCEDURE	ТҮРЕ	AMOUNT	SPECIFIC TIMES	FLOW
Catheterization				
Feedings	 G-Tube - J-Tube NG-Tube - Special 			
Suctioning	 Oropharynx Tracheostomy Deep 			
Tracheostomy	Surface Tube Replacement Care (Cleaning)			
СРТ				
Oxygen /Misting				
Ventilator				
Nebulizer Tx				
Pulse Oximeter				

List any emergency precautions / health emergencies that should be anticipated for this student; e.g. allergy triggers, reactions, etc.) :

*Prescriber's Name (Printed)

*Prescriber's Telephone & Fax Numbers

*Prescriber's Signature

*Date of Administration to Begin

Prescriber's Office Address

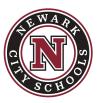
*Date of Administration to Cease

PARENTAL PERMISSION FOR MEDICATION

I grant the board, or person designated by the board, permission to assist or perform the administration of each treatment/procedure to or for my child during the school day, including when he/she is away from school property for official school events. If my child has been authorized by his/her provider to self-administer their treatment, I grant permission for my child to self-administer their treatment at school and when they are away from school property for official school events. In the event that my child is unable to self- administer their treatment, I give permission for the board, or person designated by the board, to perform the administration of the prescribed treatment. NOTE: school personnel may administer only treatments authorized by a physician. It is your responsibility to notify the school when there is a change in treatment regimen.

Parent / Guardian Name (Printed)

Signature of Parent / Guardian



Date Signed Revised August 2021 Best Number(s) to reach