REQUEST FOR MEDICAL PROCEDURE / NURSE DIRECTED MEDICATION ADMINISTRATION

Requests for school nursing services during school hours requires that this statement be filed with the school principal. **Consideration of this request will be based on school health guidelines.** Please respond to every item on this form. Only totally completed forms will be honored.

School _____ School Hours _____ Teacher _____ Grade ____

Student Name _____ Date of Birth _____ / _____ / _____
Last First Middle

Address _____ Telephone _____

Medical Conditions (Optional) _____ Cell Phone _____

HEALTH CARE PROVIDER STATEMENT

The health care provider may be a medical doctor (MD, DO), dentist (DDS), physician assistant (PA), or an advanced nurse practitioner (APRN/NP).

To be completed by health care provider- A new form is required each school year:

Type of Procedure:_____

Frequency of Procedure: _____

(For Tube Feedings Only) Type of Formula: _____

Amount: _____

Special Instructions: For suctioning, please give a description of physical conditions which would require suctioning ordered PRN: _____

Name of Drug:_____ Allergies:_____

Date to Start: _____ Through: _____

Dosage, Route and Times at School:_____

Special Instructions for Storage and Handling: _____

Possible Side Effects: _____

If the dose of this medication is different from the manufacturer's : _____
recommended dose range for the age or weight please include _____
your rationale for prescribing outside of these recommendations. _____

Health Care Provider Name:_____ Phone:_____

Address: _____Fax :_____

Health Care Provider Signature: _____Date: _____

Pursuant to HIPAA regulations, 45 C.F.R. §164.506 and § 1654.501, I may disclose protected health information regarding this student's treatment activities to be implemented by the school nurse program.

To Be Completed by Parent / Guardian

I understand I am requesting a Medical Procedure/Medication Administration be performed for my child. I understand a qualified individual will perform such procedure and/or administer such medication. I understand that all medications provided to the school for use must be labeled by the pharmacist and in the original container. Changes during the year require a signed authorization from the health care provider. I understand that to properly perform this health care procedure, the school nurse program 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 school nurse.

Parent / Guardian Name: (Please Print) _____

Parent/ Guardian Signature _____ Date _____