BIG WALNUT LOCAL SCHOOLS | INSPIRE & GUIDE

Dear Parent/Guardian and Physician:

Students in need of specific medical procedures/treatments during school hours must meet the following requirements:

1. Parents/guardians must present to the principal and school nurse a signed consent and physician's written authorization for the procedure/treatment. The physician's authorization and parent's consent will be maintained in the Student Health Record.
2. The parent/guardian's signed consent and physician's authorization must be in place before the student receives the specific medical procedure/treatment.
3. The physician's authorization must include: the student's name, date of birth, address, telephone number, diagnosis, name of procedure/treatment, reason for and any precautions or possible adverse reactions to the procedure/treatment that authorized personnel may expect.
4. The parent/guardian must meet at school with the principal, school nurse and other authorized school personnel to initiate the specific medical procedure/treatment.
5. Supplies to provide a specific medical procedure/treatment must be provided by the parent/guardian. All equipment and supplies that are required must remain in the school if possible.
6. Physician authorization for specific medical procedures/treatments must be renewed at the beginning of each school year if the student continues to need the procedure/treatment.
7. If any adjustments (i.e. technique, frequency, medications) are made, a new Physician Authorization, and Parental Consent Form will be required.
8. All equipment and supplies kept in the school will be stored in a secured area accessible only to authorized administering personnel. Such storage will be at the risk of the parent/guardian. Big Walnut Local Schools (BWLSD trained persons) assume no responsibility for possible loss of or damage to equipment and supplies.
9. One week after expiration of the physician's order, the equipment and unused portions of the supplies must be collected by the parent/guardian, or they will be discarded.

(over)

AUTHORIZATION FOR MEDICAL PROCEDURE/TREATMENT

Student Information:

Student Name:_____Birthdate:_____School Year:_____

Address:_____School_____Grade level_____

Height:_____Weight:_____

PART I: PARENT/GUARDIAN CONSENT FORM

Parent/Guardian: Please complete and sign this action.

I hereby request and authorize the School Nurse or a trained Big Walnut School District employee to perform _____

SPECIFIC MEDICAL PROCEDURE/TREATMENT

on my child_____ as prescribed by the physician below.

I have read the information on the reverse side of this form and agree to assume responsibilities as required.

_____ _____

SIGNATURE OF PARENT/GUARDIAN RELATIONSHIP TO CHILD DATE

PART II: PHYSICIAN'S SPECIFIC MEDICAL PROCEDURE/TREATMENT AUTHORIZATION ORDER

Physician: Please complete and sign this action.

NAME: _____DIAGNOSIS:_____ _____

SPECIFIC PROCEDURE/TREATMENT:

_____ _____

DATE TO BEGIN: _____DATE TO END:_____

REASON FOR PROCEDURE/TREATMENT:

_____

INSTRUCTIONS:

_____

PRECAUTIONS:

_____

POSSIBLE ADVERSE REACTIONS:

_____

Physician Signature:_____ Physician Name:_____