



PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR TREATMENT

Name of Student: Birth date: Grade/Track: School/District: Teachers Name:

California Education Code Section, 49423.5 allows the school nurse to train monitor and supervise non-medical school personnel to assist students who require treatment during the school day.

I request that the following treatment(s) be administered to my child as ordered by the authorized health care provider:

I understand that designated non-medical school personnel will administer treatment under supervision of a qualified School Nurse. I will notify the school immediately and submit a new authorization form if there are ANY changes in the treatment and/or prescribing authorized health care provider.

Parent/Guardian Signature: Date:

Telephone: (Work) (Home) (Other)

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR TREATMENT

Treatment:

Time schedule and/or indication:

Precautions, possible untoward reactions, and recommend intervention(s):

Nursing practice standards will be used for the above stated treatment UNLESS there are specific modifications or recommendations needed as checked below:

() a. Implement the treatment using nursing practice standards along with the following modifications:

() b. Implement the treatment using nursing practice standards along with my attached recommendations.

Authorized Health Care Provider Signature:

Telephone:

Date of Request:

Date to Discontinue Treatment:

Office Stamp



SCHOOL USE:

REVIEWED BY: DATE:

This request is valid for a maximum of one year.