SAHUARITA UNIFIED SCHOOL DISTRICT #30

SCHOOL HEALTH SERVICES

Authorization to Administer Physician Prescribed Treatment/Procedure

Valid for 1 school year. To be completed and signed ANNUALLY by an **Arizona Licensed Physician/Health Care Provider**

Child's Name:_____ Date of Birth:_____
School: _____ Grade:_____

I, the undersigned, the parent/guardian of (student) _____ request that the following specialized physical health care treatment/procedure be administered to my child during school hours:

Physician Prescribed Treatment/Procedure:

_____
_____

- ✓ I understand that I am responsible for providing current physician orders and all necessary supplies and equipment, labeled. The prescription must state child's full name, treatment to be provided by the school, directions to complete treatment including time, frequency, and duration of treatment, and physician signature.
- ✓ I am aware that there is not a school nurse available to complete this treatment/procedure; therefore this treatment/procedure will need to be completed by Unlicensed Assistive Personnel. I understand that the appointed qualified unlicensed assistive personnel who will perform the task will be indirectly supervised with intermittent direct supervision by the school nurse, a licensed professional nurse (RN).
- ✓ I understand that I am responsible for training the Unlicensed Assistive Personnel who are assigned to complete this treatment/procedure. A qualified school nurse will be present at the training, and will provide additional instruction as needed to ensure the Unlicensed Assistive Personnel are trained in the standards of care for the treatment/procedure.
- ✓ I understand that I am responsible for notifying my child's physician that the treatment/procedure will be completed by Unlicensed Assistive Personnel.
- ✓ I understand that I must notify the school immediately if my child's health status changes, diet changes, we change physicians, or the procedure is changed or canceled. We understand any changes must have a physician's signature.
- ✓ We understand that, whenever possible, the health maintenance tasks should be provided before or after school hours. This assures that the student receives maximum educational time.
- ✓ The school is authorized to provide emergency medical services for my child whenever the need for such services is necessary.

I authorize the school nurse, school health assistant, and the following Unlicensed Assistive Personnel to complete the specialized physical health care treatment/procedure as listed above:

School Health Assistant:

_____

Unlicensed Assistive Personnel:

_____
_____

Arizona Licensed Physician/Healthcare Provider Signature authorizes the School Nurse, Health Assistant, Extended Resource Teacher, Health Inclusion Assistant, or Authorized Designee perform the above health care tasks as indicated.

Provider's Printed Name _____ **Phone:** _____

Provider's Signature: _____ **Date:** _____

Parent/Guardian's Name: _____ Phone Number: _____

Parent/Guardian's Signature_____ Date: _____