

TREATMENT FORM

CHILD'S NAME _____

ID# _____

ROOM/DIV# _____

TREATMENT PROCEDURE REQUESTED _____

PERMIT FOR AUTHORIZED NURSING PERSONNEL
TO ADMINISTER REQUIRED TREATMENT
DURING SCHOOL HOURS

TO BE COMPLETED BY PHYSICIAN

DATE _____

This Student, _____ is under my medical care for
_____ and is required to have the
following treatment administered during school hours.

TREATMENT ORDER Air conditioned bus

EQUIPMENT SIZE _____

FREQUENCY OF TREATMENT _____

DURATION OF TREATMENT _____

SIDE EFFECTS/PRECAUTIONS _____

TO WHAT DEGREE CAN THE STUDENT PARTICIPATE IN TREATMENT PROCEDURE

INDEPENDENT _____ NEEDS ASSISTANCE _____ UNABLE TO ASSIST _____

SIGNATURE OF PHYSICIAN _____

PRINTED NAME OF PHYSICIAN _____

ADDRESS _____

TELEPHONE/PAGER# _____

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I, _____ give permission for my child,
_____ to receive the above treatment(s) as directed by
the physician. I will provide all supplies needed for the procedure. I will also provide written
notification from the physician if the treatment changes or is discontinued.

DATE _____ PARENT/ GUARDIAN _____

Telephone (cell) _____ Address _____