

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.

G TUBE FEEDING

TREATMENT ORDER _____

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** _____