ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

CHICAGO PUBLIC SCHOOLS | CPS

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 Shared nurse on the bus + in the school building

EQUIPMENT SIZE _____

FREQUENCY OF TREAMENT _____

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** _____