Quincy Public Schools District 172

AUTHORIZATION AND PERMISSION FOR SPECIALIZED MEDICAL TREATMENT

Student Name _____

ID #_____DOB _____Grade/School year_____

This order is valid for school year (current) _____ including summer session

LICENSED PRESCRIBER AUTHORIZATION

Related medical diagnosis:		
Specialized medical treatment to be administered:		
Special instructions for treatment:		
Possible side effects/adverse reactions to treatment: □ None expected □ Specify:		
Time of administration:	If PRN, frequency:	
Self-administration authorized: □ Yes □ No		
Licensed Prescriber's Name/Title (please print)		
Address	Phone	Fax
Licensed Prescriber's Signature		Date

PARENT/GUARDIAN AUTHORIZATION

- I request designated staff to administer the medical treatment as prescribed by the licensed provider above.
- I agree to furnish all equipment, supplies, medication, formulas, and/or other necessary items for the administration of the medical treatment and to provide replacement and maintenance as necessary.
- I certify that I have legal authority to consent to the administration of medical treatment at school.
- I authorize the school nurse to communicate with the licensed provider regarding the medical treatment.
- I agree to notify the school nurse immediately if there is any change in the student's status or licensed provider's orders.

Parent/Guardian Signature		Date
Home phone	Work Phone	Cell Phone

DISCONTINUATION/HOLD CONFIRMATION OF TREATMENT FROM PRESCRIBER

Confirmed by:	*Date Confirmed:*