# Intermediate School District 917
## *Consent for Administration of Special Health Care Procedures*

**Student** _____ **Birth Date** _____ **School Year** _____

**Primary Dx** _____ **ICD-10** _____

**Dx** _____ **ICD-10** _____ **Dx** _____ **ICD-10** _____

This form is used for specialized procedures which may include, but not be limited to administration of oxygen, urinary catheterization or wound care procedures which may be needed and provided for a student while he/she attends school. The procedure(s) may be performed by school personnel trained and supervised by a Licensed School Nurse.

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### Parent/Guardian Authorization

❑ I authorize the school nurse to contact the licensed provider as needed concerning this medication/s.

Provider/Clinic _____ Phone # _____ Fax # _____

- I understand that parent/guardian authorization is required for any prescription medication to be given at school. Prescription medications must have a physician or licensed provider authorization.
- I understand that I must provide all medication(s) and equipment for the procedure(s) below.
- I understand all medications must be provided with an accurately labeled prescription container. (Please ask your health provider for the medication to be divided into two containers-one for school, & one for home) Nonprescription medications must be in an original container with label and directions.
- I will notify the school immediately if my child's health status changes or there is a cancellation of the procedure(s).
- The medication may not necessarily be administered by a school nurse. The medications may be administered by school personnel trained and supervised by a licensed school nurse.
- I have read this *Parent/Guardian Authorization* section and agree to the instructions it provides.

**Parent/Guardian Signature** _____ **Date** _____

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### Physician's Orders

Procedure _____

Instruction _____

_____

Time/interval procedure is to be done _____

Amount (if applicable) _____

Precautions and/or adverse reactions _____

_____

_____

**Physician's Signature** _____ **Date** _____

*For office use only:*
LSN Signature _____ Date _____

Name of Staff Routing _____ Date _____

**Please check off who was routed this form** ___Student File __ IEP Manager ___ 917 LSN ___Building Nurse