Request for Medical Procedure in the School Setting

REQUEST FOR MEDICAL PROCEDURE

Requests for school nursing services during school hours requires that this statement be filed with the Health Service Department.
Consideration of this request will be based on school health guidelines.

School ______________________ Teacher ______________________ Grade __________

Student Name ______________________________________ Date of Birth _____ / ______ / __________

Address ____

Telephone ______________________ Cell Phone ______________________________

Medical Conditions ____

HEALTHCARE PROVIDER STATEMENT

The health care provider may be a medical doctor (MD, DO), dentist (DDS), physician assistant (PA), or an advanced nurse practitioner (APRN/NP).
To be completed by health care provider- A new form is required each school year:

Type of Procedure: ____

Frequency of Procedure: ____

Special Instructions: Please detail instructions for tracheostomy care, suctioning, or catheterization care, please describe physical conditions which would require suctioning ordered PRN: ____

____

____

____

Health Care Provider Name: ______________________________________ Phone: ______________________

Address: ____ Fax : ______________________

Health Care Provider Signature: ______________________________________ Date: ______________________

Pursuant to HIPAA regulations, 45 C.F.R. §164.506 and § 1654.501, I may disclose protected health information regarding this student's treatment activities to be implemented by the school nurse program.

To Be Completed by Parent / Guardian

I understand I am requesting a Medical Procedure to be performed for my child. I understand a qualified individual will perform such a procedure. Changes during the year require a signed authorization from the health care provider. I understand that to properly perform this health care procedure, the school nurse program may require clarification from the health care provider to assist them in the treatment activities I requested. I understand that the health care provider may disclose protected health information in consultation with the school nurse.

Parent / Guardian Name: (Please Print) ____

Parent/ Guardian Signature ______________________________________ Date ______________________