PHYSICIAN'S AUTHORIZATION for MEDICAL TREATMENT at SCHOOL

This order expires on ______________________________ or at the end of the current school year.

School: ____

Student's Name: ____________________________________Date of Birth: ______________________

Parent(s): ____

Treatment: #1 ____

Specify treatment type: ☐ Daily ☐ Emergency ☐ As Needed

Time to be performed at school: ____

If prn, allowable frequency:____

Desired action of treatment: ____

Medical concerns related to the treatment:____

Treatment: #2 ____

Specify treatment type: ☐ Daily ☐ Emergency ☐ As Needed

Time to be performed at school: ____

If prn, allowable frequency:____

Desired action of treatment: ____

Medical concerns related to the treatment:____

Treatment: #3 ____

Specify treatment type: ☐ Daily ☐ Emergency ☐ As Needed

Time to be performed at school: ____

If prn, allowable frequency:____

Desired action of treatment:____

Medical concerns related to the treatment:____

Physician's Name: ____________________________________ **Telephone:** ____________________
(Print)

Physician's Signature: ________________________________ **Fax #:**_______________________
(Original signature only)

____
Date

PARENT'S PERMISSION

I hereby request that my child (named above) receive the above medical treatments during school hours per the physician's order. I will not hold the GLPS Board of Education or its personnel responsible for complications related to the medical treatments. I authorize school personnel to consult with the above physician regarding my child's health condition/medication and to exchange information by telephone, fax and written correspondence.

____________________	______________	______________	______________
Parent Signature	Home Phone	Emergency Phone	Date

GRAND LEDGE PUBLIC SCHOOLS DO NOT HAVE MEDICAL PERSONNEL PRESENT TO ADMINISTER MEDICATION/TREATMENT, IF APPROPRIATE, PLEASE ORDER MEDICATION/TREATMENT TO BE ADMINISTERED AT HOME.

MEDADM-HR 05/02