

Wayne County Schools Authorization for Medical Treatment at School



SERVICE
LEADERSHIP
COLLABORATION
EXCELLENCE

Each procedure must be prescribed on separate forms. School districts require a written order and parent/guardian authorization for medical procedures to be done at school. It is expected that medical procedures will be performed at home unless absolutely necessary. Medical procedures will be scheduled by the school in coordination with the student's educational program.

STUDENT'S NAME: _____ DATE OF BIRTH: _____ UIC#: _____

ATTENDING DISTRICT: _____ TEACHER: _____ GRADE: _____

TO BE COMPLETED BY THE PHYSICIAN:

Print name of Physician: _____

Conditions for which Specific Medical Procedure is being prescribed: _____

If the Specific Medical Procedure is a tube feeding, please indicate type of formula and amount to be given at each feeding:

Frequency and duration of prescribed treatment: *(i.e. prior to meals)*

Restrictions and/or important side effects/interventions: _____

Reactions to be reported to physician: YES NO Describe: _____

Order Start Date: _____ Order End Date: _____

(If no stop date is specified, order will expire in one (1) year).

This prescription covers school-based treatment for one year. **NOTE: To participate in Medicaid School Based Services, a valid prescription MUST be signed by a physician and include the date the prescription was signed. The prescription must also include the physician's name, address, telephone number and NPI number. Stamped signatures are invalid for school-based services.**

Signature: _____ Date: _____

Print Name: _____ NPI # _____

Address: _____

Phone: _____ Fax: _____

PARENT/GUARDIAN AUTHORIZATION

I hereby request that school personnel give my child _____ the Specific Medical Procedure ordered above by the physician and will not hold the Board of Education or its personnel responsible for complications related to the medication pursuant to P.A. 451 or 1976-S1178. Staff may contact the physician regarding administration of the medication if necessary.

Signature: _____ Relationship: _____ Date: _____

Please return completed form to: _____ Fax: _____