

**FREDERICK COUNTY PUBLIC SCHOOLS/FREDERICK COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH PROGRAM**

TREATMENT AUTHORIZATION FORM

This order is valid only for the current school year _____ (Including Summer Session)

OR

Start Date: ___/___/___ to Stop Date: ___/___/___

This treatment authorization form must be completed fully in order for staff to administer required treatment. A new form must be completed at the beginning of each school year.

HEALTH CARE PROVIDER AUTHORIZATION

Name of Student:	Date of Birth:
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Allergies:	Grade:
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Primary Diagnosis:

Medical Treatment to be Administered:

Time of Administration:	If PRN, frequency:
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Health Care Provider's Name/Title: (Type or Print)

Telephone:	Fax:	Use for Health Care Provider's Address Stamp
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Address:	
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Health Care Provider's Signature:	Date:
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PARENT/GUARDIAN AUTHORIZATION

I request designated staff to administer the medical treatment as prescribed by the health care provider above. I certify that I have legal authority to consent to the administration of a medical treatment at school

Parent/Guardian Signature:	Date:
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Parent/Guardian Phone:	Work Phone:
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SELF-ADMINISTRATION OF TREATMENT AUTHORIZATION/APPROVAL

Self-administration of medical treatment must be authorized by the health care provider and approved by the school registered nurse.

Health care provider's authorization for: Self-administration: <input type="checkbox"/> Yes <input type="checkbox"/> No	Signature:	Date:
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School registered nurse approval for: Self-administration: <input type="checkbox"/> Yes <input type="checkbox"/> No	Signature:	Date:
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Order reviewed and signed by school registered nurse:	Date:
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