Government of the District of Columbia
Department of Health
Community Health Administration
MEDICAL PROCEDURE/TREATMENT PLAN

NAME OF STUDENT:_____ DATE OF BIRTH:_____

SCHOOL:_____ TEACHER/GRADE:_____

PART I: PARENT/GUARDIAN/RESPONSIBLE PERSON AUTHORIZATION AND CONSENT

Parent/Guardian: Please complete and sign this section.

I hereby request and authorize the School Nurse to administer the prescribed treatment as directed by the licensed

Practitioner to _____ . This treatment is a ____ new (or) ____ renewal treatment.

If new treatment, enter the date and time the first treatment was given at home. Date:_____ Time:_____a.m./p.m.

_____ _____ _____

SIGNATURE OF PARENT/GUARDIAN PHONE RELATIONSHIP

_____ _____ _____

PLEASE PRINT NAME WORK/CELL PHONE DATE

PART II: LICENSED PRACTITIONER'S AUTHORIZATION FOR TREATMENT

Physician/Nurse Practitioner: Please complete and sign this plan. ____New ____Renewal ____Change

NAME OF STUDENT:_____ DATE OF BIRTH:_____

TREATMENT:_____

TIME &FREQUENCY AT SCHOOL:_____

DIAGNOSIS:_____

EXPECTED DURATION OF TREATMENT: _____

Special instructions or emergency procedures:_____

_____

_____

Treatment plans must be updated and the school nurse immediately notified when there is any change in the student's health or treatment requirements. Otherwise treatment plans are updated annually.

_____ _____

LICENSED PRACTITIONER SIGNATURE DATE

_____ _____

PLEASE PRINT NAME OFFICE PHONE

Please use an office stamp or clearly print the names of any other Licensed Practitioners in your practice concurrently treating this student.

Treatment authorization received by:

_____

SIGNATURE OF CSS NURSE

_____

DATE

Revised 8-1-15