



MINNEAPOLIS PUBLIC SCHOOLS

Urban Education. Global Citizens.

Minneapolis Public Schools Health Related Services



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Authorization for Administration of Special Health Care Procedures (Such as tracheostomy care, gastrostomy feedings, bladder catheterization, etc.)

Parents/guardians requesting specialized health care procedures to be administered by school staff are required to provide annual written permission signed by the parent/guardian and the child's health care provider.

Student: BD: ID#:

School: School year: Grade/Rm:

Physician/licensed prescriber's order for Administration of Health Care Procedures by School Personnel

\*NEW 2015-16 School Year: Medical Diagnosis & ICD-10-CM Code MUST be completed by Physician/Licensed Prescriber\*

TO BE COMPLETED BY HEALTH CARE PROVIDER

Table with 7 columns: Medical Diagnosis, ICD-10-CM Code, Treatment/Procedure(s), Instructions, Time or Interval to be done, Amount if Applicable, Precautions/Adverse Reactions. Rows 1 and 2 are empty.

Other considerations/directions:

Start date: Stop date:

(All authorizations expire at the end of the school year.)

Signature of Physician/Licensed Prescriber Print name of Physician/Licensed Prescriber Date

Clinic address Phone Fax

TO BE COMPLETED BY PARENT/GUARDIAN

Parent/Guardian Authorization

- 1. I request that the above health care procedure(s) be done during school hours as ordered by my child's physician/licensed prescriber. I also request the health care procedure(s) be given on field trips, as prescribed.
2. I will notify the school of any change in the procedure(s), (i.e., change in time or amount, procedure is stopped, etc.).
3. I give permission for the procedure(s) to be done by school personnel as delegated, trained, and supervised by the school nurse.
4. Legally, I may refuse to sign for the treatment. If I refuse to sign, we will not be able to provide the treatment at school.
5. This consent may be revoked at any time, by sending a written notice to the licensed school nurse.

NOTE: Supplies for procedure(s) are to be provided from home.

Permission for Release of Information

- 6. I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition(s) and the prescribed procedure(s).
7. I give permission for the school nurse to consult with my child's physician/licensed prescriber about any questions regarding the prescribed procedure(s) or medical condition(s) related to the procedure(s).
8. I give permission for the physician/licensed prescriber to release information related to the above procedure(s) and medical condition(s) to the licensed school nurse.

Parent/Guardian Signature Date Relationship to Student

RETURN TO: Phone: Fax: RN, Licensed School Nurse