



MINNEAPOLIS
PUBLIC SCHOOLS
Urban Education. Global Citizens.

Minneapolis Public Schools Health Related Services



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

Medical Condition	Treatment/ Procedure(s)	Instructions	Time or Interval to be done	Amount if Applicable	Precautions/ Adverse Reactions
1.					
2.					

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

Parent/Guardian Authorization

- 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 done on field trips, as prescribed.
- I will notify the school of any change in the procedure(s), (ex: change in time or amount, procedure is stopped etc.).
- I give permission for the procedure(s) to be done by school personnel as delegated, trained and supervised by the school nurse.
- 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.
- This consent may be revoked at any time, by sending a written notice to the licensed school nurse.

Parent/Guardian Signature

Date

Relationship to Student

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

Permission for Release of Information

- I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition(s) and the prescribed procedures.
- 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 conditions(s) related to the procedure(s).
- 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

Pro.Guide/Authorization for Sp Care Procedures

Revised 8/03