___ TREATMENT AUTHORIZATION FORM

BELLEVUE SCHOOL DISTRICT 2020-2021

Name:	_____	DOB:	_____	Date:	_____	
School:	_____	Grade/Teacher:	_____			

This section to be completed by the HEALTH CARE PROVIDER (please print)**:** (MD, DO, ND, DMD, DC, PA, ARNP or CNM)

NATURE of treatment:	
FREQUENCY or TIME of treatment:	
SPECIFIC equipment required:	
ROUTE, circle one:	Oral / Nasal /Topical/Other: _____
Reason/Diagnosis:	
Side effects:	
Is student capable of self-carry & safe administration?*	□ Yes - student instructed in proper use □ No - may not self-administer
***Checking "Yes"** indicates that student has been thoroughly instructed in the purpose and appropriate method/frequency of use of treatment/procedure. Student/parent/guardian understand the responsibilities of self-administration/treatment at school.	
Authorization for:	□ School year □ Other dates:
I request that the above named student be administered the above medication in accordance with the instructions indicated, as there exists a valid health reason which makes administration advisable during school hours.	

Licensed Health Care Provider's signature:	**Date:**	_____	**Phone:**	_____
_____ ***Signature authorizes medication for length of school year***	**School year:**	_____	**Fax:**	_____

This section must be completed by the PARENT / GUARDIAN: (please print)

Please check only one box & sign below:

□ *I request that the authorized persons at **school assist my child** with the treatment/procedure described below.*

□ *I request that my child be allowed to **self-carry and self-perform this treatment/procedure**.* Student/parent/guardian understands the responsibility of self-carrying and self-performing treatment/procedure at school and recognizes that the school will not be able to track compliance. As a parent/guardian of the student, I agree to hold harmless and indemnify the school and Bellevue School District's officers, employees, and agents against all claims, judgments, or liabilities arising out of the self-administration of the treatment/procedure by their student.

□ *I am 18 years old and signing this form on my own behalf (RCW 26.28.015 or RCW 70.02.130).*

I hereby request the medical procedure named above for my child in accordance with the orders and instruction of the physician. I give permission for the procedure to be provided by a school nurse or a non-licensed employee who has received training from the nurse. I understand that it is my responsibility to provide the equipment necessary for this procedure. I am the parent or legal guardian of the child named.

- *My signature gives permission for exchange of information between the School Nurse and the Health Care Provider regarding this medication order.*

_____ Date: _____ Phone: _____

Parent / Guardian / Student signature

In most cases where a student needs treatment/procedures they can occur before and/or after school hours at home. In the event that there exists a valid health reason which requires the involvement of school personnel in the administration of treatment/procedures to a student during school hours, the following procedures shall apply consistent with RCW 28A.210.320, RCW 28A.210.260 and the Washington State Nurse Practice Act.

A prior written request and authorization (over) from the parent/guardian **and** the prescribing licensed health care provider must be on file.

1. Any over-the-counter non-prescription medication or procedure.
2. Written authorization will be effective for the current school year unless a shorter time period is specified by the licensed health care provider.

Parent/Guardian responsibilities:

- Complete the 'parent/guardian' section of form.
- Have Health Care Provider fill out 'health care provider' section of treatment/procedure authorization form.
- Ensure form is *completed* before returning form to school
- Provide appropriate equipment and supplies.
- Track the expiration date for supplies at school and resupply as needed
- ***Parents/Guardians please note:*** *Your child's health information, IHP and medication is for use during the school day only. Extended day, childcare, clubs, before & after school, evening, and summer activities* ***do not have*** *access to this IHP or medication kept in the Health Room.*

School responsibilities:

- Persons who administer medical treatments include School Nurses and any employee trained and supervised by a school nurse in proper procedures for treatment/procedure.
- Medical treatments will be recorded on an individual log sheet

Legal references:
RCW 28A.210.320 Children with life-threatening health conditions — Medication or treatment orders
RCW 28A.210.260 Public and private schools — Administration of medication — Conditions
RCW 28A.210.270 Public and private schools — Administration of medication — Immunity from liability — Discontinuance, procedure

School Nurse:	, RN	**Email:**	@bsd405.org	**Phone:**	425-456-
				Fax:	425-456-

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