Washington County Public Schools

Meritus Health School Health Program

Attach Photo	**TREATMENT AUTHORIZATION FORM** This order is valid only for the current school year ______________ (Including summer school) **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 * Carefully review the reverse side of this form before completion *

Name of Student:	*Date of Birth:*	*Grade:*

HEALTH CARE PROVIDER AUTHORIZATION

Condition for which treatment is being administered:

Allergies:

Treatment Instructions:

Time of Administration:	***If PRN, frequency:***

Is student competent to self-administer treatment? ☐ **Yes** ☐ **No**

Health Care Provider's Name/Title: (please print)		*Health Care Provider Stamp*
Telephone:	Fax:	
Address:		

Health Care Provider's Signature: ***Date:***

PARENT/GUARDIAN AUTHORIZATION

I request designated personnel to administer the treatment as prescribed by the health care provider above. I certify that I have legal authority to consent to the administration of treatment at school and understand that the health care provider will be contacted if questions arise regarding the student's treatment order.

Primary Contact Phone:	***2nd Phone:***

Parent/Guardian Signature: ***Date:***

REGISTERED NURSE REVIEW / AUTHORIZATION

Is the student competent to self-administer treatment? ☐ Yes ☐ No

Registered Nurse Signature: ***Date:***

A verbal order was taken by the school RN (name) _________________ for the above medication on (date) _____________
Verbal order must be followed by a signed order within 1 day.

IMPORTANT INFORMATION

For Parents/Guardians and Health Care Providers

1. The school nurse will call the prescriber as allowed by HIPAA if a question arises about child and/or child's medication.

2. Please give your child any needed treatment at home if at all possible.

3. It is recommended that the first full day's (24 hours) treatment be given at home. If unsure, follow the recommendation of the health care provider about attending school during the first 24 hours.

4. Parent/guardian responsibilities:
   a. Provide and maintain all equipment and supplies for the duration of the treatment order.
   b. The parent/guardian must provide new supplies prior to the expiration date(s).

5. The parent/guardian or student may demonstrate how to administer the treatment to the staff person who will monitor or administer the treatment and provide information regarding potential adverse effects.

6. Student Self-Administer Treatment:
   a. If the health care provider indicates that the student is competent to self-administer and/or self-carry, the school registered nurse shall then certify that the student possesses the skills and maturity necessary to self-administer and/or self-carry in the school setting.
   b. If the health care provider and school registered nurse both determine that the student is capable to self-carry and/or self-administer, the principal and school registered nurse shall establish procedures for the student to self-carry and/or self-administer.
   c. The principal and/or school registered nurse may revoke the authority of a student to self-carry medication if the student fails to follow the proper procedures, rules, and regulations for self-carry/self-administration, including if the student endangers anyone through the misuse of the medication.

7. The registered nurse must review and approve the form prior to administration.

8. Please give your child any needed treatment at home if at all possible.