

Parental Consent for Physician Prescribed Services

The school recognizes the desirability of following a physician's recommendations for physician prescribed services (PPS) at school whenever possible.

The fact that this is a service or accommodation which the school is not legally required to perform is recognized by all parties signing this form, and in so signing they agree to hold the school and its staff free from any liability which might otherwise arise out of these arrangements. PPS which can be administered before or after school instead of during the school day will not be administered by school staff. We (I) understand that the school district is not required by law to provide physician-prescribed services to our (my) child and therefore in consideration of the school district's agreeing to administer such PPS we (I) agree to hold the school district and its employees free from any and all responsibility for the results of such PPS or the manner in which it is administered and to indemnify each of them against loss by reason of civil judgment arising out of these arrangements which may be rendered against them.

We (I) agree to provide the school with necessary equipment and supplies, properly labeled, with proper directions for use in school.

We (I) the undersigned, who are the parent(s) or guardian(s) of _____ request that PPS be administered to our child in accordance with the attached instructions of our physician, Dr. _____, as set forth on the attached form entitled Physician's Request for Prescribed Services. We (I) understand that such PPS is to be administered by a member of the school staff to be designated by the principal.

We (I) will notify the school immediately if we change physicians or if PPS is to be changed. You are requested to continue such PPS until notified by us or our physician to discontinue such PPS and where such notice is given orally, it shall be confirmed in writing within 24 hours.

We are (I am) aware that this PPS may be administered by non-medically trained staff.

We (I) hereby grant permission for school staff to communicate directly with the physician named above.

We (I) certify that the above-named physician is aware of all medication currently being administered to this child.

The school is authorized to secure emergency medical services for my child whenever the need for such services is deemed to be necessary by the principal, school nurse or school staff member.

Father's (guardian's) name _____
Father's address _____ Home Ph _____ Business Ph _____
Signature of father/guardian _____ Date _____
Mother's (guardian's) name _____
Mother's address _____ Home Ph _____ Business Ph _____
Signature of mother/guardian _____

Both parents must sign this form if they are living with or have custody of the child.

Physician Request for Administration of Prescribed Services

1. Name of Pupil _____ Birth Date _____
2. Address _____ City _____ State _____ Zip _____
3. Condition to be treated _____
4. Prescribed service _____
5. Medication/service to be administered only until: _____
Date

6. Check one:

- _____ I have reviewed and approved the Procedures for Administration of Medication and Prescribed Services as written.
- _____ I have reviewed and approved the Procedures for Administration of Medication and Prescribed Services with my modification.
- _____ I have attached my recommendation for Procedures for Administration of Medication and Prescribed Services.

7. Precautions, possible side effects/toxic effects, recommended interventions, indications withhold and parameters for parents and/or physician notification:

8. Time schedule and/or indications of prescribed service (Prescribed service may only be scheduled during school hours.) Prescribed services which can be administered before or after school instead of during the school day will not be administered by school staff.

Medication	Dosage	Route	Hour to be given
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Special directions for administration (example: with food)

9. I am aware that this prescribed service may be administered by non-medically trained staff.

10. I will notify the school of prescribed service/medication changes.

11. This is a list of all medications taken by this child.

Physician's Name _____ Address _____

City _____ State _____ Zip _____ Phone _____

Physician's signature _____ Date _____