School District ACES **School** _____

TREATMENT / PROCEDURE AUTHORIZATION IN SCHOOL

This authorization is in effect for the school year: [ ] School Year is defined as July 1st to June 30th

Name of Student _____ **Date of Birth** _____

Procedure:
☐ Suctioning ☐ Emergency Trach Replacement ☐ Oxygen
☐ Enteral Feeding ☐ Emergency G-Tube Replacement ☐ Other:_____

Instructions: _____

_____

_____

Time of Procedure _____ ☐AM ☐PM ☐ PRN

Frequency Q _____ Hours

Provider Name & Phone/fax Numbers (printed or stamped)

Prescriber's Signature _____ **Date:** _____

Parent/Guardian Authorization

I hereby request that the above ordered procedure be performed by school personnel. I understand that I must provide the school with adequate supplies necessary to perform the procedure.

I also authorize communication between the prescribing health care provider and school nurse necessary for the safe performance of this procedure and the management of the condition for which it is prescribed.

Parent/Guardian Signature: _____ Date: _____

Parent's Home Phone# _____ Work/ Cell # _____