

PROCEDURE

ST. LANDRY PARISH SCHOOL BOARD
PUPIL APPRAISAL CENTER
127 BLAIR STREET
OPELOUSAS, LA 70570

Dear Parent or Guardian:

We would like to inform you of the Louisiana State Guidelines that are in place to ensure the health, safety, and welfare of children who need procedures during the school day. The following forms must be on file in your child's health record before we begin to train anyone to perform the procedures at school.

We also require a meeting with the parent and the child prior to beginning procedure training.

1. Parental Consent Form signed and dated by the parent or guardian.
2. Procedure Order Form filled out, signed, and dated by child's doctor.
3. Emergency Plan filled out, signed, and dated by parent or guardian.


Thank you for your cooperation in helping us provide safe procedures at school.

I have read and understand the above rules that must be complied with, in order for my child to receive a procedure at the school setting.

Parent's / Guardian's Signature

Date

School Nurse's Signature


Alvado C. Willis
Director of Special Education

**ST. LANDRY PARISH SCHOOL BOARD
PUPIL APPRAISAL CENTER
127 BLAIR STREET
OPELOUSAS, LA 70570**

PARENT / GUARDIAN CONSENT TO ADMINISTER PROCEDURE

NAME OF STUDENT _____

DATE OF BIRTH _____ SEX _____

SCHOOL _____

GRADE _____ TEACHER _____

1. I give permission for the school nurse or the designated unlicensed person, trained to administer procedures, according to the guidelines stated in Bulletin 1909, to perform the following procedure at school:

_____ NAME OF PROCEDURE

to _____ NAME OF STUDENT

prescribed by _____ NAME OF DOCTOR

2. **Parent is responsible for providing all medical supplies.**

3. I give permission to the school nurse to obtain information relative to the prescribed procedure, from the above named physician, and share it with appropriate school personnel.

Restrictions on release _____ Yes _____ No _____

4. Mode of transportation: Private vehicle _____ School Bus _____ Other _____

If riding bus, please give Bus# _____ Bus Driver _____

Signature of Parent / Guardian

Date of Signature

**STATE OF LOUISIANA
PHYSICIAN'S AUTHORIZATION
FOR SPECIAL HEALTH CARE**

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN AND PHYSICIAN

Part 1: CONTACT INFORMATION

Student Name:	Last	First	M.I.	Sex	DOB:	Grade:	School Year:
				<input type="checkbox"/> M			
				<input type="checkbox"/> F			

I hereby request that the treatment specified below be performed on my child. I understand the procedure/treatment may be performed by trained, unlicensed personnel.

Parent or Legal Guardian Name (print)	Parent/Legal Guardian's Signature	Date
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PART 2: PHYSICIAN TO COMPLETE.

PHYSICAL CONDITION FOR WHICH THE STANDARDIZED PROCEDURE IS TO BE PERFORMED:

NAME OF STANDARDIZED PROCEDURE: Please include specific instructions/orders for each procedure separately.

- | | | | |
|--|---|--|-------------------------------------|
| <input type="checkbox"/> catheterization | <input type="checkbox"/> gastrostomy care | <input type="checkbox"/> tracheostomy care | <input type="checkbox"/> suctioning |
| <input type="checkbox"/> oxygen | <input type="checkbox"/> blood glucose monitoring | <input type="checkbox"/> Other _____ | |

STUDENT SPECIFIC EMERGENCIES

IF YOU SEE THIS	DO THIS

TIME SCHEDULE AND/OR INDICATION FOR THE PROCEDURE: _____

SPECIAL INSTRUCTIONS / EQUIPMENT: _____

CALL THE DOCTOR IF: _____

THE PROCEDURE IS TO BE CONTINUED AS ABOVE UNTIL:

_____ UNTIL THE END OF SCHOOL or DATE TO END: _____

Physician Name (print)	Physician's Signature	Date
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Address	Phone	Fax
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RETURN COMPLETED FORM TO SCHOOL NURSE AS SOON AS POSSIBLE

****NOTE: Any future change in directions for this procedure requires new orders. Each medication ordered must be written on separate order form. Orders sent by fax are acceptable (337) 948-3644.**

ST. LANDRY PARISH SCHOOL BOARD

EMERGENCY PLAN

Name of Student_____ Teacher_____ Grade_____

Name of Parent / Guardian_____

Phone Numbers: Home _____ Work _____ Cell _____

Alternate Adult Contact Person: (1) _____ Phone# _____

Alternate Adult Contact Person: (2) _____ Phone# _____

Relationship of alternate persons to student: (1)_____ (2)_____

Physician's Name _____ Phone Number _____

Poison Control Number: 1-800-256-9822

Student's allergy history: _____

(List all medications, food, plants, insects, etc. that your child is allergic to)

Field Trip Designated Person: Trained Personnel _____

Parent/Guardian _____

Alternate Adult Person _____

I am aware that if my child has an emergency in school and I am not available, the school principal or alternate will have my child transported to the emergency room, and I will be responsible for payment of emergency care.

IF AN EMERGENCY OCCURS, SCHOOL PERSONNEL WILL DO THE FOLLOWING:

- 1. If the emergency is life threatening, immediately call 9 – 1 – 1.**
- 2. Stay with the student, or designate another adult to do so.**
- 3. Contact the parent/guardian, or alternate adult (named above).**
- 4. Follow school protocol.**
- 5. Contact school nurse at your child's school.**

Signature of Parent/Guardian

Date Signed