Collingswood Public Schools
SCHOOL MEDICAL PROCEDURE AUTHORIZATION FORM

This form must be completed fully in order for schools to perform medical procedures. A new procedure authorization form must be completed at the beginning of each school year, for each procedure, and each time there is a change in dosage or time of a procedure.

- All equipment and supplies must be provided by Parent/Guardian to Certified School Nurse.
- Non-prescription medication/equipment must be in the original container with the label intact.
- An adult must bring the supplies to the school.
- The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medical procedures.
- Efforts will be made to employ a substitute nurse to accompany the class when students with health/medical needs on field trips; however, the district cannot guarantee the availability of a substitute nurse**.**
- **A parent or guardian may accompany the student on a field trip for the purpose of medical procedure.**

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

Diagnosis/Condition: _____

Medical Procedure: _____Dose: _____Route: _____

Time/frequency: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: □None expected □Specify: _____

This procedure may be omitted on half-days and field trips: _____ YES _____ NO

This order is valid only for school year (current) _____to_____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____
(Type or print)
Telephone: _____FAX: _____

Address: _____

_____

Prescriber's Signature: _____Date:_____
(Original signature or signature stamp ONLY) (Use for Prescriber's Address Stamp)

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the Medical Procedure as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up medical supplies, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____