COUNCIL ROCK SCHOOL DISTRICT
Bucks County, Pennsylvania

Authorization for Specific Medical Procedure to be Performed by the School Nurse

The Council Rock School District requires a physician's written order and parent/guardian authorization for a specific medical procedure to be done in school.

PHYSICIAN'S ORDER

Student Name: _____DOB:_____

Date of order: School Year: _____

Medical Diagnosis: _____

Name of specific medical procedure: _____

Time(s) of administration: _____
(May be flexible according to parent/student schedule)

Tube Feedings Only:
Type of formula:_____
Method of feeding: _____Pump _____Gravity _____Syringe
Amount/feeding:_____
Water bolus: _____

Specific Medical Procedure is to be done as above:

From _____ To _____ _____
Date Date Physician's Signature

_____ _____
Phone number Physician's printed name

Parent/Guardian Consent

I give my permission for my child,
_____, to receive the following procedure ordered by a licensed prescriber during the school day and release the Council Rock School District and its employees from liability for any damages my child may suffer because of this request. I understand that by signing this form, I give permission to the school nurse to contact the licensed prescriber for further clarification/medical information if needed.

Parent/guardian signature: _____DATE:_____
Parent/guardian printed name:_____Phone:_____