THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
Health Services
J. E. Hall Center, 30 E. Texar Dr.
Pensacola, FL 32503
Phone: 469-5456

AUTHORIZATION FOR HEALTH PROCEDURE/TREATMENT

THIS FORM IS VOID IF ALTERED IN ANY WAY

INSTRUCTIONS: Each section must be completed by the appropriate person as follows: Parts I and III by Parent/Guardian, Part II by Physician. Please return the completed form to the school health room/office.

Student's Name (Last, First, Middle)	Birth Date	Medicaid Number	Grade/Homeroom Teacher
Parent/Guardian	Address		
Phone	Work Phone	other Phone (cellular phone, beeper, etc.)	

II. TREATMENT PLAN (To Be Completed By Prescribing Physician).

This request is to be effective for the school year 20____-20____ or Earlier Stop Date: ____________

Diagnosis: ____________ Procedure/Treatment: ____________

Time schedule for Procedure/Treatment: ____________

Student specific instructions for Procedure/Treatment: ____________

Student specific Precautions, Possible Complications, and Recommended Intervention(s):

Print Physician's Name	Physician's Address	Phone

Physician's Signature: Date:

III. PARENTAL PERMISSION (To Be Completed By Parent/Guardian).

I hereby request the school's personnel, or its agents to provide the above prescribed procedure or treatment. I give permission for my child to receive this procedure/treatment while in school or while participating in school activities away from the school site. I understand that there is no liability on the part of the school district, its personnel, or its agents, including Escambia County Health Department personnel, for civil damages as a result of the administration of the procedure/treatment to my child when the person performing the procedure/treatment acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and school health personnel of the Escambia County Health Department and the School District of Escambia County. Furthermore, if my child is covered by Medicaid and receives health services under an IEP, I consent for the school district to bill Medicaid for those services.

Parent/Guardian Signature: ____________ Date: ____________

9400-HES-006 Revised: July 11, 2006

The School District of Escambia County, Florida
Guidelines for Performing Health Procedure/Treatment

The performance of health procedures/treatments is the responsibility of the parent/guardian unless it is absolutely essential to the well being of the student to receive the health procedure/treatment during the school day. The following guidelines must be observed when performing a health procedure/treatment in the school setting:

1. An Authorization for Health Procedure/Treatment form must be completed and signed by the physician, and parent/guardian.
2. A separate authorization form must be filled out for **EACH** procedure/treatment to be provided.
3. Authorization forms are valid for one school year, or earlier stop date.
4. Changes in procedure/treatment require a new authorization form completed and signed by the physician and parent/guardian.
5. According to Florida Statute, Section 1006.062, a registered nurse or specifically designated and trained personnel of the school district or the health department will perform procedures.
6. All equipment, maintenance or repair, and supplies necessary to perform the procedure/treatment must be provided by parent/guardian.
7. Parent/guardian is responsible for cleaning/maintaining required supplies that are necessary to perform procedure/treatment.
8. A responsible adult must deliver and pick-up any equipment and/or supplies in the school clinic.
9. Communicate any procedure/treatment changes directly to clinic staff, including discontinued procedure/treatment.
10. When procedure/treatment is discontinued or school year ends, pick-up all supplies within one week. Unclaimed supplies will be destroyed.

PERSONNEL TRAINED IN INDIVIDUAL STUDENT'S CARE
(To Be Completed By School Nurse)

Health Procedure/Treatment: ______________________________

Trained Provider's Name	Verbalizes understanding of procedure	Identifies complications and appropriate action steps	Performs per guidelines	Comments	School Nurse's Signature/Date