Williamson County Schools
Procedure Authorization Form

(This form must be signed by the Physician)

Student Name _____ Date of Birth_____

School_____ Grade_____ School Year_____ Date _____

This form provides health care provider and parental authorization for the medical treatment to be provided during school hours. Both the prescribing health care provider and the parent/legal guardian are required to complete this document before the services can be provided.

Note: Physicians orders are required for all medical procedures administered at school and a separate form is required for each procedure. Please have your child's physician complete this portion of the form and return it to the school.

PHYSICIAN'S ORDER (Required)

The following section is to be completed by the prescribing physician or health care provider. The student named in this document is under my medical supervision for the health condition described below. I have prescribed the following necessary procedure/treatment to be given during school hours for the student's health or safety. I am also aware that the prescribed treatment may be administered by trained non-medical personnel.

1. Health Condition for which procedure is required_____
2. Procedure/Treatment_____

   Tube Feeding only: Type of formula_____ Amount_____
3. Time or frequency _____
4. Equipment required_____
5. Precautions, adverse reactions, detailed instructions, or criteria to contact physician:

_____

_____

6. The student can perform the procedure with the assistance of a trained adult. ☐ Yes ☐ No

Physician's Signature_____ **Date** _____

Physician's Name (Print)_____ **Phone** _____

PARENT/GUARDIAN'S AUTHORIZATION (Required)

I authorize this procedure to be performed by the school nurse or the nurses delegate as directed above. I agree to provide the needed supplies for the procedure and understand that new forms must be completed annually or with any changes in the student's health status. By signing this document, I give permission for the nurse or nurse designee to administer this procedure as prescribed and give permission for this Health Care Provider to share information about this procedure with the Nurse or nurse designee. In addition, I consent to communication between the school nurse and healthcare provider or clinic to discuss the procedure if clarification is required. The undersigned parent(s) or guardian(s) hereby agree(s) to exempt and release the school district and its directors, officers, employees, volunteers and agents from any and all liability, claims, demands, or actions whatsoever arising out of any damage, loss, or injury that my student or I/we might sustain or which they now have or may hereafter have arising out of the administration of this procedures.

Parent/Guardian's Name (Print)_____ **Phone**_____

Parent/Guardian's Signature_____ **Date**_____