PINELLAS COUNTY SCHOOLS

SCHOOL HEALTH SERVICES

AUTHORIZATION FOR IN-SCHOOL TREATMENT/PROCEDURE

Student Name ____ Birthdate: ______________________

School ______________________________________ Grade ____ Teacher ________________________

Parent/Guardian Name ____________________________________ Parent/Guardian Phone ______________

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1. Condition to be treated/Diagnosis is ____________________________
2. Treatment: **For tube feeding, complete only PCS Form 2-3163.**

   ☐ Urinary Catheterization   ☐ Tracheostomy Care   ☐ Colostomy Care

   ☐ Other ____

3. Precautions, possible reactions and recommended intervention(s) ____________________________________

   ____

4. Time scheduled during school hours

   ____

5. The above treatment/procedure cannot be scheduled for other than during school hours and may be administered by non-licensed trained personnel when appropriate. The school nurse is authorized to instruct non-licensed trained personnel in the administration of this treatment/procedure and permission is hereby given for non-licensed trained personnel to perform the treatment/procedure as set forth herein, if deemed appropriate.

6. Physician's Signature ____ Date ______________

   Physician's Name (Printed) ____ Telephone __________

   Address ____ City _____________ Zip ________

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I hereby request and give permission for my child to be given the above prescribed treatment/procedure while in school and away from school for activities. I also grant permission for the school to contact the prescribing physician with questions/concerns related to the procedure.I will notify the school immediately if the health status of my child changes, we change physicians, we change home, work or emergency telephone numbers, or there is a change or cancellation of the treatment/procedure. I understand that if there is special equipment needed to perform this treatment/procedure, it will be provided by me, delivered to the school in good working order, and that school personnel will assume no responsibility for the proper maintenance and/or delivery of this special equipment necessary for this treatment/procedure. I hereby release, waive, and hold the Pinellas County School Board and its agents and employees harmless from any and all claims, judgements, and liability resulting from injuries or damages, grounded in tort or otherwise, that I and/or the student(s) named above incur as a result of any actions taken that I authorize hereunder.

Parent/Guardian Signature: ____ Date: __________

School Nurse Signature: ____ Date: __________

A NEW AUTHORIZATION IS REQUIRED EACH SCHOOL YEAR