Baltimore City Health Department SCHOOL HEALTH PROGRAM	Request to Administer Treatment in School

To Parent/Guardian: To request treatment at school please note:

- **This form must be completed and signed by you and your child's medical provider.**
- **Complete one form per treatment. A new form is needed for any treatment change including change in administration time.**
- **The medical provider is asked to provide a detailed description of the treatment and name of medication required.**
- **It is the responsibility of the family to provide all treatment related equipment and supplies.**
- **Treatments will be performed according to standard nursing practice.**

Medical Provider's Order for Treatment in School

Student_____ DOB_____ School _____

Treatment_____

Equipment to be Used With Treatment:

_____ _____ _____
_____ _____ _____

Description of Treatment to be Administered:

_____
_____
_____
_____

Medication (s)_____Strength_____
Dose_____ Route_____ Time(s)_____
Dose_____ Route_____ Time(s)_____

Treatment should begin_____(date) and terminate ____ end of school year
____ other–*DATE* _____

Medical Provider's Name (please print)_____Date _____
Medical Provider's Signature_____Telephone_____
Address_____ Fax #_____

Discontinue Treatment (signature) _____ Date _____

I request and authorize health staff from the Baltimore City Health Department, School Health Program to administer treatment in accordance with the above medical provider's order. In so doing, I agree not to hold the Baltimore City Health Department staff responsible for any ill effects resulting from the administration of this treatment.

Parent/Guardian Signature_____Date____/____/____
Parent Phone #_____ Emergency Phone #_____
Form received by health staff on____/____/____ by_____
Reviewed by_____, R.N./L.P.N. on ____/____/____