Government of the District of Columbia
Department of Health
Community Health Administration
MEDICAL PROCEDURE/TREATMENT PLAN

NAME OF STUDENT:___________________________________ DATE OF BIRTH:_____________________________________

SCHOOL:____ TEACHER/GRADE:___________________________________

PART I: PARENT/GUARDIAN/RESPONSIBLE PERSON AUTHORIZATION AND CONSENT

Parent/Guardian: Please complete and sign this section.

I hereby request and authorize the School Nurse to administer the prescribed treatment as directed by the licensed

Practitioner to ____ . This treatment is a ____ new (or) ____ renewal treatment.

If new treatment, enter the date and time the first treatment was given at home. Date:____________ Time:__________a.m./p.m.

______________________________	______________________	______________________
SIGNATURE OF PARENT/GUARDIAN	PHONE	RELATIONSHIP
______________________________	______________________	______________________
PLEASE PRINT NAME	WORK/CELL PHONE	DATE

PART II: LICENSED PRACTITIONER'S AUTHORIZATION FOR TREATMENT

Physician/Nurse Practitioner: Please complete and sign this plan. ____New ____Renewal ____Change

NAME OF STUDENT:____ DATE OF BIRTH:________________________________

TREATMENT:____

TIME &FREQUENCY AT SCHOOL:____

DIAGNOSIS:____

EXPECTED DURATION OF TREATMENT: ____

Special instructions or emergency procedures:____

____

____

Treatment plans must be updated and the school nurse immediately notified when there is any change in the student's health or treatment requirements. Otherwise treatment plans are updated annually.

______________________________________	______________________
LICENSED PRACTITIONER SIGNATURE	DATE
______________________________________	______________________
PLEASE PRINT NAME	OFFICE PHONE

Please use an office stamp or clearly print the names of any other
Licensed Practitioners in your practice concurrently treating this student.

Treatment authorization received by:

____

SIGNATURE OF CSS NURSE

____

DATE

Revised 8-1-15