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 CSS Personnel and trained School Employees to administer the prescribed treatment as directed by the licensed Health Care Provider 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 HEALTH CARE PROVIDER'S AUTHORIZATION FOR TREATMENT

Health Care 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 CSS Personnel immediately notified when there is any change in the student's health or treatment requirements. Otherwise treatment plans are updated annually.

____ ____________________________________

LICENSED HEALTH CARE PROVIDER SIGNATURE OFFICE PHONE DATE

____ ____________________________________

PLEASE PRINT NAME EMAIL ADDRESS

____ ____________________________________

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

Treatment authorization received by:

____

SIGNATURE OF CSS PERSONNEL

____

DATE