ANNE ARUNDEL COUNTY SCHOOL HEALTH SERVICES

Parent's Request To Perform Treatment Procedure

To Parents:

The undersigned parent(s) (or guardian) of _____ hereby request(s) personnel employed by either the Anne Arundel County Public Schools or the Anne Arundel County Health Department
to see that said child receives _____ _____**AS PRESCRIBED**
(treatment)

BELOW BY THE CHILD'S PHYSICIAN. It is required by the Anne Arundel County Public Schools and Anne Arundel County Health Department as a condition to its agreement to administer any treatment that the parent must supply the school with supplies for all procedures and be present for the first time a treatment is performed. It is understood that the treatment is administered solely at the request of and accommodation to the undersigned parent(s) or guardian. In consideration of the acceptance of the request to perform this service by any personnel employed by either Anne Arundel County Public Schools or Anne Arundel County Health Department the undersigned parent(s) or guardian hereby agree(s) to release the said institutions and their personnel from any legal claim(s) which they now have or may hereafter have arising out of the performance of the treatment to the student.

I understand that this procedure will be performed using standard nursing procedures. If the procedure is uncomplicated and my child's condition is stable; the school nurse may, at her discretion, teach unlicensed personnel this procedure. School or health personnel may assist toward independence in care if indicated.

School child attends _____

_____ _____
Signature of Parent or Guardian Date

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PHYSICIAN'S SIGNED ORDER FOR TREATMENT AT SCHOOL

Name of Student _____ Date of Birth _____
Last First M.I.

Diagnosis _____

I request the following Treatment Procedure be administered during school hours:
Please list any specific precautions personnel should be aware of or any unusual effects that might be observed.

_____
_____
_____

Services should begin _____ and terminate **August 2023**
Date Date

_____ Physician's Signature _____
Physician's Name (Printed) Address _____
Phone _____ Date _____

_____
Signature of Reviewing School Nurse