ALEXANDRIA CITY PUBLIC SCHOOLS
AUTHORIZATION TO PROVIDE TREATMENT/PROCEDURE IN SCHOOL

Name of student: _____ Grade: _____
School Year: _____ Name of School: _____
Birth Date: _____

PART I: TO BE COMPLETED BY PARENT/GUARDIAN:
I request that the treatment/procedure as described by my physician/licensed health care provider be administered in school by the Alexandria City Public Schools school nurse or principal's designee.

I understand that I must supply the school with the equipment/supplies listed as necessary for the treatment/procedure.

Name: _____ _____
(Signature) (Printed name)
Telephone Number: _____ _____ _____
(Home) (Work) (Cell/Emergency)

PART II: TO BE COMPLETED BY A PHYSICIAN OR LICENSED HEALTH CARE PROVIDER:

Describe treatment/procedure to be administered:
_____
_____

Primary diagnosis/pertinent history:
_____
_____

Equipment/Supplies necessary for procedure:
_____
_____

Treatment start date: _____ End date: _____

Physician/Licensed Medical Provider's Name: _____ _____
(Signature) (Printed/Stamped)

Telephone Number: _____ Fax Number: _____ Date: _____

PART III: TO BE COMPLETED BY SCHOOL NURSE:

Check as appropriate:
_____ Part I and Part II completed with all information
_____ Equipment and Supplies provided

Nurse Signature: _____ Date: _____