ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

Chicago Public Schools

CHICAGO PUBLIC SCHOOLS

PHYSICIAN'S INSTRUCTIONS FOR SKILLED NURSING CARE PROCEDURE OR TREATMENT

(Last Name) (First) (Middle) (BD) (ID No.)

Home Address Zip Code Other Town

Father's Name Mother's Name Telephone

School Grade Non-Attending

PERMIT FOR AUTHORIZED LICENSED NURSING PERSONNEL TO ADMINISTER REQUIRED TREATMENT DURING SCHOOL HOURS

TO BE COMPLETED BY PHYSICIAN

This child _____is under my medical care for _____

_____and is required to have the following treatment administered during school hours.

Treatment Order _____

Parameters (If indicated) _____

Equipment Size _____

Frequency of Treatment _____

Duration of Treatment _____

Side Effects/Precautions _____

To What Degree Can Child Participate in Treatment Procedure?

Independent ☐ Needs Assistance ☐ Unable to Assist ☐

Physician's Name _____ **Hospital Affiliation** _____
(Please print or type)

Address _____ **Telephone #** _____ **Fax #**_____

Physician's Signature _____ **Date** _____

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I, _____, give permission for my child, _____, to receive the above treatment (s) as directed by the physician. I will provide all supplies needed for the procedure. I will also provide written notification from the physician if the treatment changes or is discontinued.

DATE _____ PARENT/GUARDIAN _____
Signature

Rev 1/19