HEALTHY CPS

— OFFICE OF STUDENT HEALTH & WELLNESS —

PROVIDER'S INSTRUCTIONS FOR SKILLED NURSING CARE PROCEDURE/TREATMENT
(PLEASE USE A DIFFERENT FORM FOR EACH PROCEDURE REQUESTED)

STUDENT'S NAME____ DOB_________
ID#___________________________ SCHOOL ________________________GRADE_____________

PROCEDURE/TREATMENT REQUESTED:____

PERMIT FOR AUTHORIZED NURSING PERSONNEL TO ADMINISTER REQUIRED TREATMENT DURING SCHOOL HOURS
TO BE COMPLETED BY MEDICAL PROVIDER

PROCEDURE/TREATMENT ORDER: ☐ G-tube ☐ Catheterization ☐ Suction ☐ Trach Care ☐ Other

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EQUIPMENT SIZE:____

FREQUENCY OF TREATMENT:____

DURATION OF TREATMENT:____

SIDE EFFECTS/PRECAUTIONS:____

TO WHAT DEGREE CAN THE STUDENT PARTICIPATE IN TREATMENT PROCEDURE
INDEPENDENT_________ NEEDS ASSISTANCE_______ UNABLE TO ASSIST_______
SIGNATURE OF PROVIDER_______________________________________
PRINTED NAME OF PROVIDER____
ADDRESS____
TELEPHONE#____

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN
I, ____give permission for my child,_____________________________________to receive the above treatment(s) as directed by the provider. I will provide all supplies needed for the procedure. I will also provide written notification from the provider if the treatment changes or is discontinued.

PARENT/ GUARDIAN SIGATURE________________________________DATE_____________

Telephone (cell) ___________________ Address_____________________________