STUDENTS

Parent Request for Special Nursing Care/Medical Treatment

Name of Student_____ Birth Date_____ Grade_____

Parent's Name_____ School_____

I, _____, parent/guardian of _____ request that the following service be performed for my child by district personnel of the Pullman School District. It is my understanding that this service will be performed by non-medical personnel. It is deemed absolutely necessary that this procedure be performed during school hours to enable my child to stay in school.

Service desired:_____

_____

_____

I have obtained detailed written instructions from Dr._____, the physician who recommended this service. You have my permission to communicate freely with this physician in order to make arrangements for care and supervision of my child.

I understand service will not be started until these orders are on file in my child's school and adequate training of staff has been completed.

As parent and/or guardian of the above-named child, I agree to hold Pullman School District No. 267 harmless from any liabilities it may incur from the above-named minor in connection with the above-described service except as might arise because of negligence on the part of Pullman School District No. 267 or its employees.

_____ _____

Date Parent's Signature

_____

Address

_____

Telephone

Physician's Orders for Special Nursing Care/Medical Treatment

Name of Student _____ Birth Date_____

Parent's Name_____ School_____

In order for this student to attend school, it is absolutely necessary that the following service be performed during school hours. If specific training or instruction is necessary, I am willing to participate in this.

Service necessary (include detailed specific instructions):_____

_____

1. Time procedure/service to be performed:_____
2. Training needed for non-medical person to perform this service_____

   _____

   _____

   _____
3. Special equipment or environment recommended:_____

   _____
4. I accept responsibility for monitoring that adequate, safe arrangements are made for performance of above service.
5. I may be called by school personnel regarding the above recommendation.
6. I will be monitoring the ongoing health status of this patient.

_____ _____
Date Physician's Signature

_____ _____
Duration of Order Printed Name

_____
Address

_____
Telephone