

# Ferndale School District Treatment Order

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_  
School Nurse: \_\_\_\_\_ Teacher(s): \_\_\_\_\_  
\_\_\_\_\_

**This portion of the form is to be completed by the health care provider.**

Authorization for (Type of treatment): \_\_\_\_\_

Time(s): \_\_\_\_\_

Medication needed for treatment: \_\_\_\_\_

Route: \_\_\_\_\_; Dose per treatment: \_\_\_\_\_

Instructions: \_\_\_\_\_  
\_\_\_\_\_

I request and authorize that the above named student be provided with the treatment listed above in accordance with the instructions indicated starting \_\_\_\_\_ (date) and ending \_\_\_\_\_ (date). It is understood that these services will be provided only during school hours or during such time that the student is under the supervision of school officials. It is also understood that non-licensed school staff, in accordance with state laws for nursing delegation, may provide this treatment. This order must be **renewed annually**.

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Health Care Provider Name (Print or type)

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**This portion of the form is to be completed by the parent/guardian.**

I certify that I am the parent, legal guardian, or other person in legal control of the above identified child and request and authorize the school to provide the treatment listed above to my child in accordance with the doctors instructions and orders for the period beginning the \_\_\_ day of \_\_\_\_\_, 20\_\_ through the \_\_\_ day of \_\_\_\_\_, 20\_\_ (not to exceed one school year). I understand that this treatment may be provided to my child by **non-licensed** school staff, in accordance with state nursing laws.

Parent signature: \_\_\_\_\_; Date: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work Number: \_\_\_\_\_ Cell \_\_\_\_\_

CC: