PERMISSION FOR ADMINISTERING SPECIAL HEALTHCARE TREATMENTS/PROCEDURES/MEDICATIONS (PRESCRIPTION & OTC)

Elementary 402-443-4250 ~ Middle School 402-443-3101 ~ High School 402-443-4332
Wahoo Public School Fax ~ 402-443-4731

I/We authorize the school nurse to communicate with the ordering healthcare provider and/or their staff to discuss any health care condition that is related to the prescribed medication/treatment.

I hereby authorize the school nurse/staff to administer the following treatment, procedure and/or medication to:

STUDENT NAME: _____

SCHOOL: _____

GRADE: _____

NAME OF TREATMENT, PROCEDURE AND/OR MEDICATION: _____

_____

_____

TIME SCHEDULE/INDICATION FOR TREATMENT, PROCEDURE AND/OR MEDICATION:

_____

_____

PRECAUTIONS, POSSIBLE ADVERSE REACTIONS, INTERVENTIONS AND INSTRUCTIONS:

_____

TREATMENT WILL BEGIN ON: _____ **TREATMENT WILL END ON:** _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

HEALTH CARE PROVIDER SIGNATURE: _____ **DATE:** _____

Parent/Guardian will provide supplies for needed treatment, procedure and/or medication. Treatment, procedure and/or medication directions will be **renewed each school year and amended as necessary during the school year.** Student may be transported to local healthcare facility if emergency treatment, procedure and/or medication is indicated or has been administered.

Wahoo Public Schools
2201 North Locust
Wahoo, Ne 68066