Waukegan Public Schools

Community Unit District #60

Office of School Health Services

SPECIALIZED HEALTH CARE TREATMENTS
PHYSICIAN PRESCRIPTION/PARENT PERMISSION

_____ _____ _____ _____

Student Birth Date Grade/Room Teacher

TO BE COMPLETED BY THE PHYSICIAN:

Diagnosis/physical condition for which treatment is to be performed:_____

_____

Name of treatment:_____

Precautions, possible untoward reactions, and interventions:_____

_____

_____

Time schedule and/or indication for the procedure:_____

_____

Can this treatment be completed by the student? ☐ no ☐ with assistance ☐ independently

_____ _____ _____ _____

Physician's Signature Printed Name Phone# Date

Physician's Address:_____ Fax# _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I give permission for my child,_____ to receive the above treatment as prescribed. I understand that my signature on this form constitutes a waiver by me to the school district, its employees and agents for administering of this treatment from liability for untoward reactions when the treatment is completed in accord with the prescribing State-licensed health care provider's instructions. I additionally agree to indemnify and hold harmless the school district, its employees and agents for any claims arising from the treatment by or to my child in accordance with my authorization, except those that are based upon willful and wanton misconduct. I consent to the sharing of information between the prescribing health care provider and the school nurse, and an executed authorization form is attached hereto and incorporated herein by reference.

_____ _____ _____

Parent/Guardian's Signature Daytime phone # Date

Parent please note: Treatment supplies must be provided for by the parents and brought to the school by a responsible adult. Procedure for half-days of school and field trips need to be discussed with your school nurse.

TREATMENT WILL NOT BE PERFORMED UNLESS THIS FORM IS COMPLETED IN ITS ENTIRETY