Seattle Public Schools

AUTHORIZATION FOR TREATMENTS AND PROCEDURES TO BE PERFORMED AT SCHOOL

The following section is to be completed by the PARENT/GUARDIAN: (please print)

School _____ Grade _____ Birth Date _____

Student's Name _____ _____ Sex _____
(Last) (First)

_____ _____ _____
(Health Care Provider's Name) (Address) (Phone)

Please check only one box:

☐ I request that authorized persons at school assist my child by performing the treatment or procedure described below.

☐ I (the student) am signing this form on my own behalf (RCW 26.28.015 or RCW 70.02.130) and give permission to authorized persons at school to perform the treatment or procedure described below.

☐ I give my permission for an exchange of information between the Seattle School District and the health care provider.

_____ _____ _____ _____
(Date) (Parent/Guardian/Student Signature) (Home Phone) (Emergency Phone)

The following section is to be completed by the HEALTH CARE PROVIDER: (please print)

Timing/frequency requires the procedure to be done during the school day (QID or more).

Diagnosis for which treatment/procedure is given: _____

Purpose/Goal: _____

Treatment/Procedure (describe): _____

_____

Equipment or Supplies needed: _____

_____

Time(s) Treatment/Procedure is to be done at school: _____

Times done in 24 hours (for emergency stay at school beyond the normal school day): _____

_____

Comments/Suggestions: _____

_____

Length of time this treatment/procedure is recommended: _____

_____ _____
(Date) (Health Care Provider's Signature)