# PERMISSION TO PERFORM MEDICAL PROCEDURE

Student_______________________________________ Birthdate____________
School _______________________ Grade ________ School Year _________ Parent/Guardian 1: ____________________ Parent/Guardian2:__________________
Daytime Phone (____)__________________ Daytime Phone (____)_______________
Cell (____)____________________________ Cell (____)______________________
Authorization expires at the end of the school year or following the summer school session.

**Parent/Guardian consent:**

I give permission for my son/daughter, ________________________________, to receive the following procedure(s) at the time indicated and as designated by his/her medical provider.

I will be responsible for maintaining a sufficient quantity of the supplies at the school. Failure to do this will result in an interruption of the physician's order or discontinuation of the school's administration of the procedure for my child.

I understand that, if my child refuses to allow the procedure(s), force will not be used by school personnel to make my child comply. I also give permission to exchange information between school district personnel and the health care provider regarding use, side effects, response, and contraindications of the procedure results or frequency.

I agree to notify the school in writing at the withdrawal of this request of when a change in this procedure occurs.

Parent/Guardian Signature_________________________________Date_________________

| **CONDITION(S)** | | | | | |
|---|---|---|---|---|---|
| Name of Procedure (CIC, glucose checks, suctioning, etc.): | Dosage/ Frequency | Time(s) (AM/PM): | Start date | Stop date | Monitoring Parameters |
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The above orders shall be effective throughout the current school year, summer school and through July 30th of the following school year, unless the orders are discontinued, changed or withdrawn in writing by the parent/guardian before that time elapses.

Health Care Provider's Name (Please print)________________________________Phone (____)_____________

Health Care Provider's Signature_____________________________ Fax (____)___________ Date___________



The School District of Menomonee Falls does not discriminate in employment, program opportunities, or delivery of services, WI statute, 118.13