Faribault Public Schools
Health Services Office

Medical Treatment Request and Medical Provider Authorization Form

(Procedure orders must be renewed each school year.)

Student Name: _____ Date of Birth: _____

Name of procedure: _____

Method of administration: _____

Dose of medication: _____

Precautions, possible adverse reactions, and interventions: _____

_____

Time(s) of day to be given in School: _____

Start date of procedure: _____ End date of procedure:_____

Diagnosis and medical reason for treatment: _____ ICD-10: _____

Clinic Name: _____ Clinic Telephone #: _____

Clinic Address: _____ Clinic Fax #: _____

Medical Provider Name:_____

Medical Provider Signature: _____ Date: _____

Faribault Public School's Fax Numbers:

Jefferson Elementary	Fax: 507-333-6544	Faribault Middle School	Fax: 507-333-6400
Lincoln Elementary	Fax: 507-333-6642	Faribault High School	Fax: 507-333-6111
Roosevelt Elementary	Fax: 507-333-6734	Area Learning Center (ALC)	Fax: 507-333-6048
McKinley Early Childhood Center	Fax: 507-333-6830		

Parent/Guardian Authorization and Signature Required Below

1. I request the above procedure be given during school hours as ordered by this student's medical provider.
2. I release school personnel from any liability in relation to this request when the procedure is given as ordered.
3. I will notify the school health service office of any change in the procedure (change, discontinuation of the procedure, etc.).
4. I give permission for the school health service office to communicate with school staff about this procedure on a need to know basis.
5. I give permission for the school health service office to consult verbally or in writing with the above named student's medical provider regarding any questions that arise with regard to the procedure or medical condition being treated by this procedure.

★ **Parent/Guardian Signature: _____ Date: _____**

Contact phone number/Email:_____