



**Government of the District of Columbia
Department of Health
Community Health Administration
MEDICAL PROCEDURE/TREATMENT PLAN**

NAME OF STUDENT: _____

DATE OF BIRTH: _____

SCHOOL: _____

TEACHER/GRADE: _____

PART I: PARENT/GUARDIAN/RESPONSIBLE PERSON AUTHORIZATION AND CONSENT

Parent/Guardian: Please complete and sign this section.

I hereby request and authorize CSS Personnel and trained School Employees to administer the prescribed treatment as directed by the licensed Health Care Provider to _____.

This treatment is a _____ new (or) _____ renewal treatment. If new treatment, enter the date and time the first treatment was given at home. Date: _____ Time: _____ a.m./p.m.

SIGNATURE OF PARENT/GUARDIAN

PHONE

RELATIONSHIP

PLEASE PRINT NAME

WORK/CELL PHONE

DATE

PART II: LICENSED HEALTH CARE PROVIDER'S AUTHORIZATION FOR TREATMENT

Health Care Practitioner: Please complete and sign this plan.

___ New ___ Renewal ___ Change

NAME OF STUDENT: _____ DATE OF BIRTH: _____

TREATMENT: _____

TIME & FREQUENCY AT SCHOOL: _____

DIAGNOSIS: _____

EXPECTED DURATION OF TREATMENT: _____

Special instructions or emergency procedures: _____

Treatment plans must be updated and CSS Personnel immediately notified when there is any change in the student's health or treatment requirements. Otherwise treatment plans are updated annually.

LICENSED HEALTH CARE PROVIDER SIGNATURE

OFFICE PHONE

DATE

PLEASE PRINT NAME

EMAIL ADDRESS

Please use an office stamp or clearly print the names of any other Licensed Health Care Provider in your practice concurrently treating this student.

----- ----- ----- ----- ----- -----
--

Treatment authorization received by:

SIGNATURE OF CSS PERSONNEL

DATE