HARFORD COUNTY PUBLIC SCHOOLS
TREATMENT POLICY AND PERMISSION FORM

It is occasionally necessary to administer medical treatment to students during the school day by personnel of the Harford County Public Schools. In order to do this, signed authorization is required from both health care provider and parent/guardian stipulating the information indicated below.

Student's Name: _____ Birth Date: _____

Address: _____ Phone: _____

School: _____ Teacher: _____

Health Care Provider's Authorization:

Procedure to be performed: _____

Condition for which the procedure is to be performed: _____

_____

Instructions for performing the procedure: _____

_____

Time schedule and/or indication for procedure: _____

_____

Precautions, possible untoward reactions, and needed interventions: _____

_____

Procedure to be continued until _____
(date)

Any additional comments: _____

_____

Health Care Provider's signature: _____

Phone: _____ Date: _____

Parent/Guardian Permission:
I give my permission for the procedure detailed above to be performed by school personnel. Additionally, I give my permission for the exchange of medical information between the school and_____.
(Health Care Provider)

Parent/Guardian signature: _____ Date: _____