Everett Public Schools
Health Services

TREATMENT AUTHORIZATION/ORDER (RCW28A.210.280/370)

This form is for independent, non- independent, and non delegable treatment
This order is for the current school year only

Date: ______________________ **Student Number:** ___________
Student Name: ______________________ **DOB:** ______________
School: ______________________ **Grade:** ______________
Parent/Guardian: ______________________ **Home Phone:** ______________
Work Phone: ____________ **Cell Phone:** ____________ **E-Mail:** ______________
Licensed Health Care Provider (LHCP): ______________________
Clinic Name: ______________**Office Phone:** ______________ FAX: ___________

Medication/treatments should be administered/performed at school only when absolutely necessary. Whenever possible the parent/guardian and licensed health care provider (LHCP) are urged to design a schedule outside of school hours. It is understood that trained unlicensed personnel may administer oral medication and perform some treatments per state law, but may not administer eye/ear drops or topicals (non delegable per nursing licensure). Student must be able to self administer/apply topicals, and eye/ear drops. All medication will be stored in a secure place. The medication/treatment to be given at school must have a written order signed by a licensed health care provider and have a parent/guardian signature**. Any medication must be in the original, properly labeled container. This includes any over the counter medication and office samples.** The school accepts no responsibility for adverse reactions when the medication is dispensed in accordance with the licensed health care provider order.

I certify that this student requires the following treatment/medication during school hours (determined by licensed health care provider authorizing treatment).

Diagnosis: ______________________

Treatment/Medication and level of self care:

- **Catheterization** ☐ Independent ☐ Needs Assistance
  Time of treatment: ______________________
- **Colostomy Care** ☐ Independent ☐ Needs Assistance
  Time of treatment: ______________________
- **G-Tube Feeding** ☐ Independent ☐ Needs Assistance
  Feeding Solution: ____________ **Amount:** ____________ **Time(s):** __________
  Amount of water to follow feeding: ______________________
  Medication via tube: ____________ **Dosage:** ____________ **Time(s):** __________
- **Nebulizer Treatment** ☐ Independent ☐ Needs Assistance
  Medication: ____________ **Dosage:** ___________**Time(s) of treatment:** ___________
- **Ear Drops** ☐ Independent ☒ Non-delegable
  Time of treatment: ______________________
- **Eye Drops** ☐ Independent ☒ Non-delegable
  Time of treatment: ______________________
- **Topicals (ointments/creams/lotions)** ☐ Independent ☒ Non-delegable
  Time of treatment: ______________________
- **Other:** ____________ ☐ Independent ☐ Needs Assistance
  Time of treatment: ______________________

Specific treatment instructions: ______________________
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Other comments/concerns: ______________________
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Licensed Health Care Provider Signature: ______________________ **Date:** ____________
Parent/Guardian Signature: ______________________ **Date:** ____________
Student (if independent): ______________________ **Date:** ____________
District Nurse: ______________________ **Date:** ____________