MONTGOMERY COUNTY PUBLIC SCHOOLS
CLEAR FORM

MONTGOMERY COUNTY PUBLIC SCHOOLS
MONTGOMERY COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
Rockville, Maryland 20850

AUTHORIZATION TO PROVIDE MEDICALLY PRESCRIBED TREATMENT
Release and Indemnification Agreement

PART I – TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize Montgomery County Public Schools (MCPS) and Montgomery County Department of Health and Human Services (DHHS) personnel to provide the medically prescribed treatment directed by the physician (Part II, below). I agree to release, indemnify, and hold harmless MCPS and DHHS and any of their officers, staff members, employees, or agents from lawsuit, claim demand, or action, etc., against them, for providing the treatment to this student, provided MCPS and DHHS staff are following the physician's order as written in Part II, below. I am aware that the treatment may be provided by an officer, staff member, employee, or agent of MCPS and/or DHHS who is a non-health professional who has received training from a licensed health professional.

Student Name _____ Birthdate ____/____/____ School Name _____

_____ _____ _____ _____ ____/____/____
Signature, Parent/Guardian *Telephone* *Date*

PART II – TO BE COMPLETED BY THE PHYSICIAN

I understand that treatments may be administered in MCPS by non-health professionals. These individuals may be employees of MCPS who volunteer to administer the treatment(s), or the DHHS School Health Room Aide. These persons will be trained by the School Community Health Nurse to give the specific treatment.

Student Name _____ Diagnosis _____

Treatment _____

Frequency and time(s) to be provided at school _____

If not needed on a routine basis, specify when indicated _____

Treatment orders effective: ____/____/____ To ____/____/____

Possible complications and/or special considerations _____

Equipment needed for treatment, including any special care and handling _____

Symptoms/observations to be reported _____

List other condition(s) and/or diagnosis(es) of student that staff need to be aware of _____

_____ _____ _____ _____ _____ ____/____/____
Physician's Name (Print or type) *Telephone* *Original Signature, Physician* *Date*

PART III – TO BE COMPLETED BY THE PRINCIPAL AND SCHOOL COMMUNITY HEALTH NURSE

Part I and II above are completed including signatures.

_____ _____ _____ _____ _____ ____/____/____
Signature, Principal *Telephone* *Signature, School Community Health Nurse* *Date*

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INSTRUCTIONS/INFORMATION

"Medically prescribed treatment" does not mean "medical services" as defined in the regulations of the ***Individuals with Disabilities Education Act,*** 34 C.F.R. Section 300.13, and/or the *Code of Maryland Regulations,* 13A.05.01.02. **This form is to be used in consultation with the School Community Health Nurse for treatments such as: urinary catheterization, tracheostomy, gastrostomy feedings, and oral suctioning. These are only illustrations of typical treatments and not an all inclusive listing. Consult with School Community Health Nurse for further information.**

1. The parent/guardian is responsible for obtaining the physician's instructions (Part II) on this form, signing it (Part I) and returning it to the school. It is valid only during the school year in which it was signed. A new form must be submitted each year, and each time there is a change in medical treatment or conditions under which the treatment is given.

2. The principal **and** school nurse will ensure that all items on the form are completed. **This form must be on file in the student's health folder.**

3. It is the responsibility of the parent/guardian to furnish the equipment necessary to provide the treatment and to maintain the equipment in good working order. Further, it is the responsibility of the parent/guardian to collect any equipment provided no later than one week after the end of the school year.

4. Medical treatments will not be administered in school or during school sponsored activities without the parent's/guardian's signed authorization and waiver and a physician's statement.