Authorization to Provide Medically Prescribed Treatment

Release and Indemnification Agreement

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

CLEAR FORM

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 authorized prescriber (Part II, below). I agree to release, indemnify, and hold harmless MCPS and DHHS and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for providing the treatment to this student, provided MCPS and DHHS staff are following the authorized prescriber's orders as written in Part II. 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: Last _____ First_____ MI____

MCPS ID#_____ Date of Birth ____/____/_____ School Name -- Choose One -- _____

Signature, Parent/Guardian _____ Phone ____-____-_____ Date ____/____/_____

PART II: TO BE COMPLETED BY THE AUTHORIZED PRESCRIBER

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

Treatment_____Diagnosis_____

Frequency of administration (ranges not accepted, i.e. every 2 to 4 hours) _____

If PRN specify when indicated (signs/symptoms) _____

Treatment orders effective ❑ Current school year, ***or*** ❑ Effective dates ____/____/_____ 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

Authorized Prescriber's Name (print/type)_____

Authorized Prescriber Signature _____

Phone Number _____-_____-_____ Date ____/____/_____

PART III: TO BE COMPLETED BY THE SCHOOL COMMUNITY HEALTH NURSE OR PRINCIPAL

❑ Parts I and II are complete, including signatures.

Signature, School Community Health Nurse (SCHN)/Principal _____ Date ____/____/_____

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 SCHN 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 the SCHN for further information.**

1. The parent/guardian is responsible for obtaining the authorized prescriber'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/or** SCHN 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 an authorized prescriber's statement.

5. The SCHN will call the authorized prescriber, as allowed by *Health Insurance Portability and Accountability Act of 1996* (HIPAA), if a question arises about the student and/or the student's prescribed treatment.