



Authorization for Medical Treatment at School

This portion to be completed by parent/guardian:

Student's Name: _____ Date of Birth: _____

School: _____ Teacher: _____ Grade: _____

I request Wenatchee School District personnel to perform the following treatment, listed below, for my child. I understand this treatment must be performed during school hours to enable my child to attend school. I will supply any necessary equipment needed for treatment.

Treatment: _____

Detailed, written instructions from the physician/dentist who recommends this treatment are attached to this form.

The doctor's name is: _____

Authorization to communicate with the physician/dentist is attached (WSD form SN-13-04).

Parent/Guardian Signature: _____ Date: _____

This portion to be completed by the physician/dentist:

Student's Name: _____ Date of Birth: _____

In order for this student to attend school, it is necessary the following treatment be performed during school hours. I am willing to participate if specific training or instruction is necessary.

Necessary treatment (include specific instructions): _____

Time that treatment is to be performed: _____

Training needed for non-medical person to perform this service: _____

Recommended special equipment or environment: _____

School personnel may telephone regarding these recommendations. Telephone: _____

Doctor's Signature: _____ Date: _____

Printed Name: _____ Duration of Order: _____

Address: _____