Attachment IV
Regulation 757-3

Prince William County Public Schools
Health Treatment Plan
Authorization for Specific Medical Procedure

Student Name: _____ Date: _____

Address: _____ Date of Birth: _____

Name of specific medical procedure: _____

Condition for which the procedure is to be performed: _____

Level of care: ☐ Minimum ☐ Moderate ☐ Complex

List training needed to perform procedure: _____

_____

Procedure can be completed by trained school staff: ☐ Yes ☐ No

Special orders including procedure times and/or intervals. (Attached protocol may be accepted or adapted as needed. Alternatively, a specific order may be written on the health care provider's letterhead.):

_____

_____

_____

Precautions, possible adverse reaction, interventions:

_____

_____

Materials/equipment to perform special procedure (provided by parent/guardian):

_____

_____

Medical procedure is to be performed from _____ to _____

_____ _____
Health Care Provider's Name Phone Number

_____ _____
Health Care Provider's Signature Date

Authorization of parent/guardian: I hereby request that staff perform the above procedure on my child as indicated in the Health Treatment Plan.

_____ _____
Parent's/Guardian's Name Date

_____
Parent's/Guardian's Signature

School/CCC personnel trained in the treatment procedure:

Printed Name	Signature	Trainer's Signature	Date of Training