MOLALLA RIVER

AUTHORIZATION FOR HEALTHCARE PROCEDURES

Student Name:		DOB	

As the parent of the above identified student, I request that my child receive the following health services as per written nursing protocol, nursing care plan and/or MD orders as it relates to my student's chronic diagnosis and specialized care of:

Diagnosis

- ☐ Bleeding Disorder:_____
- ☐ Cancer :_____
- ☐ Cardiac Condition:_____
- ☐ Feeding or Elimination Disorder:_____
- ☐ Musculoskeletal Disorder:_____
- ☐ Neurological Disorder:_____
- ☐ Respiratory Disorder:_____
- ☐ Thermoregulation Disorder:_____
- ☐ Other:_____

_____

Procedure

- ☐ Response to Bleeding episodes ☐ with medication
- ☐ Immunocompromised health status
- ☐ Response to Cardiac Alteration
- ☐ Individual Feeding Procedure ☐ Response to Choking
- ☐ Feeding Tube procedures ☐ Feeding Tube safety
- ☐ Catheter Procedure ☐ Colostomy Procedure
- ☐ Response Respiratory Complications
- ☐ with medication ☐ with nebulizer
- ☐ Potential _____

_____

Associated Prescriptions: ☐ Not applicable

Right Student	
Right Medication	
Right Dose	
Right Route	
Right Time	

Right Student	
Right Medication	
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I understand that:

- This authorization is valid for one year from the date of my signature below.
- Qualified, designated persons will be performing the above-mentioned health care service(s) and the designated persons will be trained and supervised by a registered nurse as authorized by OAR 851-047-0000.
- I will notify the school immediately if the health status changes, if there is a change of physicians, changes to physician's orders, and/or change or cancellation of health care.
- I am responsible for bringing to school all necessary supplies,

Parents Signature Date