

**PARENT REQUEST FOR SPECIAL NURSING CARE/RELATED MEDICAL TREATMENT PROCEDURES**

Name of Student \_\_\_\_\_ B.D. \_\_\_\_\_ Grade \_\_\_\_\_

Parent's Name \_\_\_\_\_ School \_\_\_\_\_

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_ request that the following service be performed for my child by district personnel of Issaquah School District. The procedure is not one that by law may only be performed by a physician. It is my understanding that this service will be performed by non-medical personnel. It is deemed absolutely necessary that this procedure be performed during school hours to enable my child to stay in school.

Service desired: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have obtained detailed written instructions from Dr. \_\_\_\_\_, the physician who recommended this service. You have my permission to communicate freely with this physician in order to make arrangements for care and supervision of my child.

I will provide the school with any necessary equipment or supplies needed for this related medical procedure.

I understand service will not be started until these orders are on file in my child's school and adequate training of staff has been completed.

As parent and/or guardian of the above-named child, and on behalf of the above named minor, I agree to hold Issaquah School District No. 411 and its personnel harmless from any liabilities, to the maximum extent permitted by law, **which** may incur from the performance by district personnel of the above-described service.

Date \_\_\_\_\_

Parent's Signature \_\_\_\_\_

Address \_\_\_\_\_

White: School  
Yellow: Physician  
Pink: Parent

City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone number ( \_\_\_\_\_ ) \_\_\_\_\_

Formerly: Policy No. 3418 F1