ENID PUBLIC SCHOOLS
Excellence. Pride. Success.

SPECIAL CARE/PROCEDURE
2020-2021

STUDENT

Name of Student		DOB	
School		Teacher/Grade	
Diagnosis			

SPECIAL CARE/PROCEDURE

☐ 0800 AM	☐ NOON	☐ AS NEEDED every _____hours for _____
☐ OTHER TIME (Please specify)_____		

HEALTH CARE PROVIDER

HCP Name/Title (Print)				Use for Provider Address Stamp
Telephone		FAX		
Address				
HCP Signature			Date	

PARENT/GUARDIAN

I request designated and trained Enid Public School personnel administer medication for my child as directed by this authorization. I agree to release, indemnify, and hold harmless, the school district, school personnel, employees or agents from any lawsuit, claim, expense demand or action, etc., against them for administering my child this medication.

☐ I give permission to the health care provider to release to Enid Public Schools information relating to the special care/procedure described above.

☐ I understand that the prescriber will be called if a question arises about my child's special care/procedure as allowed by HIPAA.

☐ I understand that an adult must bring the supplies/equipment for this special care/procedure to school.

☐ I understand that a new care/procedure authorization form is required each school year and for changes in the procedure

☐ I understand that at the end of the school year, an adult must pick up the procedure supplies/equipment otherwise the supplies/equipment will be discarded.

Parent/Guardian Signature		Date	
Parent/Guardian Phone #1		Phone #2	

Reviewed and approved by		School Nurse	Date	