Orenda Education
Health Services Department
Student Directed Treatment

This form allows students to self-manage/treat their medical condition while attending school or school functions, with permission from their physicians and parents. This document is to be completed and kept on file with the school nurse to allow a student to self-manage their medical condition while attending school or school functions.

Students Name: _____ Grade: _____ DOB: _____
Parent/Guardian # 1 _____ Phone(H)_____ (W)_____(C)_____
Parent/Guardian #2 _____Phone(H)_____(W)_____(C)_____

Emergency Contact _____Relationship_____ #_____

Physician: _____ Phone _____

Self Management of _____(medical condition) while attending school and school functions:

____ I have instructed _____ (student name) on the proper use of his/her specific medical supplies and/or treatments. He/She has demonstrated proficiency in self-managing his/her specific medical needs, including how and when to utilize equipment, and parameters and techniques for treating his/her condition. _____ has also exhibited knowledge of when it is appropriate to notify the school nurse/parent, including but not limited to fever, an unresolved treatment situation, poorly or non-functioning equipment, low supplies.

____ It is my professional opinion that this student should be allowed to carry the following supplies related to his/her medical condition and to self-administer the following treatments while attending school or at school related events.
I understand that the school nurse is unable to monitor a student's health condition while he/she is self-treating him/herself during the school day or at school events, unless the student notifies the school nurse of any concerns.

A. Treatment:_____
Explanation of treatment:_____
When to Use/Administer:_____

B. Treatment: _____
Explanation of treatment: _____
When to Use/Administer:_____

Supplies _____

It is my professional opinion that _____ (Students Name) should NOT be allowed to carry and self-administer any of his/her medically necessary equipment or perform any self-treatments while attending school or school functions.

Physician Signature _____ Date _____

I agree with the recommendations of my child's physician as noted above and have informed my child that he/she may self-treat his/her specific medical condition on campus. My child understands to contact the school nurse and/or myself for any unresolved medical conditions or malfunctioning equipment or low supplies.

Parent/Guardian Signature_____ Date _____