Authorization to Provide
Medically Prescribed Treatment

Release and Indemnification Agreement – School Year 2020-21

THE HEIGHTS SCHOOL
10400 Seven Locks Road
Potomac, Maryland 20854

PART I: TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize The Heights School personnel to provide the medically prescribed treatment directed by the authorized prescriber (Part II, below). I agree to release, indemnify, and hold harmless The Heights School and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for providing the treatment to this student, provided The Heights School's staff are following the authorized prescriber's orders as written in Part II. I am aware that the treatment may be provided by an officer, staff member, employee, or agent of The Heights School who is a non-health professional who has received training from a licensed health professional.

Student Name: Last ______________________________ First _________________________ MI _____

Student Date of Birth _____/_____/________

☐ I understand that any medications left with the school must be retrieved by June 10th, 2021. Any medications left at the school after that date will be discarded.

Parent Signature ____ Date _____/_____/________

Parent Full Name ____ Phone ______-______-________

PART II: TO BE COMPLETED BY THE AUTHORIZED PRESCRIBER

I understand that treatments may be administered at The Heights School by non-health professionals. These individuals may be employees of The Heights School who are designated to administer the treatments. These persons will be trained by the Designated School Health Professional to give specific treatment.

Treatment ____ Diagnosis ______________________________

Frequency of Administration (ranges not accepted, i.e. every 2 to 4 hours) _________________________

If PRN specify when indicated (signs/symptoms) ____

Treatment orders effective ☐ Current year, ***or*** ☐ Effective dates ___/___/____ to ___/___/____

Possible complications and/or specific considerations:

Equipment needed for treatment, including special care and handling:

(continued on reverse)

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PART II: TO BE COMPLETED BY THE AUTHORIZED PRESCRIBER (CONTINUED)

Symptoms/observations to be reported

List other condition(s) and/or diagnosis(es) of student that staff need to be aware of

Authorized Prescriber's Name (print/type) ____

Authorized Prescriber Signature ____

Phone number _____-_____-______ Date ____/____/_____

PART III: TO BE COMPLETED BY THE DESIGNATED SCHOOL HEALTH PROFESSIONAL OR HEADMASTER

☐ Parts I and II are complete, including signatures.

Signature, Designated School Health Professional/Headmaster ______________________________

Date _____/_____/______

Instructions/Information

"Medically prescribed treatment" does not mean "medical services" as defined in the regulations of the Individuals with Disabilities Education Act, 34 C.F.R. Section 300.13, and/or the Code of Maryland Regulations, 13A.05.01.02. This form is to be used in consultation with the Designated School Health Professional for treatments such as: urinary catheterization, tracheostomy, gastrostomy feedings, and oral suctioning. These are only illustrations of typical treatments and not an all inclusive listing. Consult with the Designated School Health Professional for further information.

1. The parent/guardian is responsible for obtaining the authorized prescriber's instructions (Part II) on this form, signing it (Part I) and returning it to the school. It is valid only during the school year in which it was signed. A new form must be submitted each year, and each time there is a change in medical treatment or conditions under which the treatment is given.

2. The headmaster and/or Designated School Health Professional will ensure that all items on the form are completed. This form must be on file in the student's health folder.

3. It is the responsibility of the parent/guardian to furnish the equipment necessary to provide the treatment and to maintain the equipment in good working order. Further, it is the responsibility of the parent/guardian to collect any equipment provided no later than one week after the end of the school year.

4. Medical treatments will not be administered in school or during school sponsored activities without the parent's/guardian's signed authorization and waiver and an authorized prescriber's statement.

5. The Designated School Health Professional will call the authorized prescriber, as allowed by Health Insurance Portability and Accountability Act of 1996 (HIPAA), if a question arises about the student and/or the student's prescribed treatment.