Authorization to Provide
Medically Prescribed Treatment

Release and Indemnification Agreement

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.

Student Name: Last _____ First _____ MI _____

Student Date of Birth _____/_____/_____

☐ I understand that any medications left with the school must be retrieved by the last day of school. 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.

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)

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 the last day of school.

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.