Administration of Treatment

Student Last Name	Student First Name	Birthdate	Gender	Allergies
			□ Male □ Female	
Parent/Guardian Name		**Parent/Guardian Phone Number**		

PHYSICIAN TO COMPLETE
PHYSICAL CONDITION FOR WHICH THE STANDARDIZED PROCEDURE IS TO BE PERFORMED
NAME OF STANDARDIZED PROCEDURE and DIRECTIONS
□ Catheterization _____ □ Supplemental oxygen administration _____ □ Gastrostomy care: GT size and type_____ amount of water in the balloon_____ □ Gastrojejunostomy care: amount of water in the balloon _____ □ Tracheostomy care: trach type and size _____ emergency trach size _____ □ Trach suctioning _____ □ Oral suctioning _____ □ Other_____
PRECAUTIONS, POSSIBLE UNTOWARD REACTIONS, AND INTERVENTIONS
TIME FOR THE PROCEDURE
PHYSICIAN SIGNATURE
Physician Signature _____ Print Name_____ Date_____

Parent/Guardian Signature

I hereby request that the treatment specified above be performed on my child.

Parent/Guardian Signature _____ Print Name_____ Date_____

This form must be completed and returned to the Health Office before treatment can be given.

Marklund Day School Elgin

1435 Summit Street, Elgin, IL 60120

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