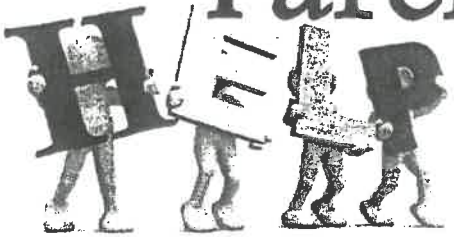

Parental Agreement Needed!!

Children's Intervention School Services Program was developed to allow school systems to receive reimbursements for services provided such as:

❖**Nursing Services**

At no cost to you or the state & no effect on the use of health services. Your participation is needed to help our schools and students with disabilities

Three easy steps

1. Complete and sign the attached form
2. Take a picture and text to the number below or return to the school nurse.
3. Text to (706) 842-8776

Your text will go directly to Chiquita Owsley in the Richmond Board of Education Office. The phone number is (706) 826-1000 if you have any questions.

Service Plan for School Based Medicaid Services
Richmond County Board of Education
Parent/Guardian SECTION

STUDENT: _____ **DOB:** ____/____/____ ☐ M ☐ F

ADDRESS: _____ **City** _____ **GA ZIP:** _____

SCHOOL: _____ **FTE or SS#** _____

____My child is receiving Special Ed. Services _____ Other Health Plan

PARENT(S)/GUARDIAN(S): _____ **HOME #:** _____

As the parent / legal guardian of the student named above I expressly authorize and give permission to the Richmond County Schools to have the designated person administer the above prescribed medication/treatment to my child. I agree that the school system and its employees shall not be liable or responsible, and shall be indemnified and held harmless for any illness or damage to any person or property which may result from the storage of medication, from giving our child medication/treatment, or from failing to give our child medication/treatment.

My child is eligible for MEDICAID OR PEACHCARE ☐ YES ☐ NO. Number _____
I understand that the school system is able to file with Medicaid or Peachcare for partial reimbursement for the administering of this medication or procedure. By signing below, I give my consent for the school system to receive this payment from Medicaid or Peachcare.
I have read this form and understand my responsibility toward the school, which is agreeing to assist me in this matter of medicating/treating my child at school. I may change / withdraw permission in writing at any time by notifying the Special Education Director.

The undersigned authorizes the prescribing physician named below to release any information to the School Board or their designee regarding the medication/treatment to be administered. I, the undersigned, authorize the Richmond County Schools to release pertinent information to the physician.

_____ _____
Signature of Parent / Guardian Living with Student **Date**

Physicians – please complete ALL items

And return to the school as expeditiously as possible.
The following medication/treatment as listed should be dispensed at school as indicated:

Medication/Treatment: _____

Diagnosis: _____

GOAL OF THIS REGIMEN OF MED./Treat. ☐ Improve Attention Span ☐ Reduce Impulsiveness ☐ Improve School Performance ☐ Control Blood Sugar Level ☐ Control Seizure Activity ☐ Prevent Respiratory Distress

☐ Other please specify: _____

Rehabilitative Potential _____

DURATION OF MED./Treat.; ☐ SCHOOLTERM ☐ Indefinitely ☐ OTHER _____

Time med./treat. is to be given at school: ☐ 7:30- 8:30 a.m. ☐ 11:00 a.m. – 12:30 p.m. ☐ Other _____ **☐ PRN**

_____ _____
Physician's Signature original – **DATE**

_____ **Physician's PHONE** _____
Please Print Physician's Name