St. Vincent's
Special Needs Services

AUTHORIZATION FOR TREATMENT BY SCHOOL PERSONNEL

The Connecticut State Law and Regulations require an authorized provider's written order and parent or guardian's authorization for a nurse to administer treatments.

NAME OF STUDENT: _____

PHYSICIAN'S ORDER FOR USE OF VEST AIR WAY CLEARANCE SYSTEM

Treatment
May use VEST system every 4 hours as needed or per parent request for secretion management with the following settings:
Frequency =
Pressure =
Time =

Length of time during which treatment shall be administered: **From:** _____ **To:** _____

PROVIDER'S NAME: _____

PROVIDERS'S SIGNATURE: _____

PROVIDER'S ADDRESS: _____

PARENT/GUARDIAN AUTHORIZATION:
I hereby request that the above treatment, ordered by the physician for my child/ward be administered by school personnel, RN/LPN.

SIGNATURE OF PARENT/GUARDIAN_____ **DATE:** _____

95 Merritt Boulevard, Trumbull, CT 06611
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