

1525 Sherman St, B76

Denver, CO 80203

303.866.3299

[**www.csi.state.co.us**](https://www.csi.state.co.us)

(enter name of CSI Charter School)

#  REQUEST FOR MEDICALLY NECESSARY TREATMENT AT SCHOOL

Student Name: Student ID # and Date of Birth: Parent/Guardian Name(s) & telephone number:

Name, Colorado License #, Address, and Telephone Number of qualified health care provider writing prescription for medically necessary treatment on School property

Name, Colorado License #, certification, or authorization, Address, and Telephone Number of private health care specialist who will provide proposed medically necessary treatment on School property

Describe in detail the proposed treatment to be provided on School property during the school day (location, time of day, services to be provided):

By signing this Request, parent(s)/guardian(s) agrees to sign a medical release authorizing the School to confer with the qualified health care provider to obtain

follow-up information about the student’s medical needs and the medically necessary treatment.

By signing this Request, parent(s)/guardian(s) acknowledges their sole financial responsibility for the services.

By signing this Request, parent(s)/guardian(s) waive liability of any and all claims against the School and CSI for any negligence, intentional conduct, malpractice, or other misconduct on the part of the Provider, including claims arising from the conduct of the Provider under the Claire Davis School Safety Act, C.R. S. § 24-10-106.3, and C.R.S. § 13-20-1201 et. seq., Actions for Sexual Misconduct Against Minors.

By signing this Request, parent(s)/guardian(s) Parents/Guardians agree to waive any claims for a Free Appropriate Public Education under the Individuals with Disabilities Act (“IDEA”) to the extent that the rendering of services by the Provider interferes or restricts any required educational or related services under the Student’s current IEP.

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| --- | --- | --- |
| Parent/Guardian Name | Signature | Date |
| Parent/Guardian Name | Signature | Date |

# Attach a copy of the Student’s prescription, recommendation or order.