Exhibit: JLCM E-1

REQUEST FOR MEDICALLY NECESSARY TREATMENT ON DISTRICT PROPERTY

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 District property _____
_____
_____

Name, Colorado License #, certification, or authorization, Address, and Telephone Number of Private Health Care Specialist who will provide proposed medically necessary treatment on District property
_____
_____

Name of Insurance Provider(s) for Private Health Care Specialist and coverage limits _____

_____ (provide insurance declarations)

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

Parent/Guardian Signature and Date _____

Signature of Building Administrator Acknowledging receipt of Form and Date _____

_____

Signature of Authorizing Administrator and Date _____

Attach a copy of the Student's Prescription from a Qualified Health Care Provider to this form.

Return Completed Form with attachments to CCSDTreatmentRequests@cherrycreekschools.org and Building Principal.