Physician Authorization for Treatment/Procedure(s)

STUDENT'S NAME_____ **SCHOOL**---------- **DOB**----------

TREATMENT (S) REQUESTED

_____

(TO BE COMPLETED BY PHYSICIAN)

This child is under my medical care for _____

and is required to have the following treatment (s) administered during school hours.

TREATMENT ORDER _____

_____

CAN STUDENT PERFORM PROCEDURE (S) INDEPENDENTLY YES NO

Comments: _____

_____

(PRINTED NAME OF PHYSICIAN)

_____

(ADDRESS OF PHYSICIAN)

_____

(TELEPHONE NUMBER)/(FAX NUMBER)

_____ **Date**_____

*(*PHYSICIAN SIGNATURE*)*

(TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN)

AUTHORIZATION: Permission is hereby granted to the Community High School District 155 *to release information* and/or *to obtain* ***information*** from the individual/organization as identified above for the purpose of the treatment(s) requested. In signing this form, I understand the following provisions:

a) I am under no obligation to sign.
b) Failure to sign will mean that the information will not be requested or released. Consequences for refusing to release this information includes, but may not be limited to, a failure on the part of the receiving party to fully appreciate, or be aware of, the client's/student's pertinent history in planning and providing service/treatment.
c) I have the right to revoke this authorization at any time by written request (except for information previously disclosed).
d) I have the right to inspect and copy the information disclosed.
e) This form authorizes the release of the information specified within one year from date of signature.

It is the parent responsibility to provide all supplies needed to perform the above treatments(s). The parent agrees to notify the school in writing if the treatment is discontinued. For the safety of your child, the School District reserves the right to refuse treatment if compliance with these guidelines is not followed or it is deemed an unsafe condition for your child.

I have read and understand the above treatment policy.

I give permission for my child to receive the above treatment(s) by assigned school personnel as directed by the Physician.

Authorized/Guardian Signature	Print Name	Date
Phone Number	Cell Number	