Richfield Public Schools
Authorization for Health Care Procedure

Health Care Provider Order

Student's Name______________________________DOB____/____/______

Diagnosis:____________________________________ICD-10 Code_______

Procedure:____

Instructions:____

____

____

(Attach more information if/as needed/indicated.)

Time(s)/Interval of Procedure:______________________________________

Precautions/Potential Adverse Reactions:____________________________

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____ ______________

Signature of Health Care Provider Date

____

Address

________________________________ ____________________________

Phone Fax

Parent/Guardian Authorization

I request that this procedure be done for the above-named student in the school setting. I understand all products needed for the procedure will be provided from home.

______________________________ _________________ _____________

Signature of Parent/Guardian **Relationship to Student** **Date**