Palo Alto
Unified School District

Specialized Health Care Procedure Authorization

School _____ School Year _____ Fax _____

Student Name _____ DOB _____

*This form **must be renewed annually**, **and** if there are any changes in treatment during the school year.*

Physician

Name/Description of Specialized Health Care Procedure: _____

_____

_____

_____

Time(s) to be performed at school: _____ ☐ Daily ☐ PRN If PRN, frequency: _____

If PRN, for what symptoms: _____

Procedure shall be administered from: _____ to _____ or ☐ Remainder of school year

Precautions, potential complications & needed actions: _____

_____

My signature below provides authorization for the above orders. All procedures will be implemented in accordance with states laws and regulations. Specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. If changes are indicated, I will provide new written authorization.

_____ _____

Physician Signature Date

_____ _____

Phone Fax Clinic Stamp

家长/监护人

我申请按照以上医疗提供方的说明，在学校为我的子女提供专门医疗服务。我授权准许学校人员按照以上医疗服务提供方的要求协助我的子女完成此特定医疗程序。我了解，经过培训的非医疗人员可以协助或负责给药（教育法 49423 和 49480）。

我同意在 PAUSD 和以上列出的医疗提供方之间，沟通和交流与医疗提供方书面声明或任何其他药物或给药问题有关的信息。

我了解并同意以下关于专门医疗程序的责任：

1. 家长将提供必要用品和设备。
2. 家长将通知学校，并为上述授权的任何改动提供新同意书。
3. 必须先获得医疗提供方的书面通知，然后才能进行以上授权的任何改动。

_____ _____ _____

家长签字 电话 日期

Health Services
25 Churchill Avenue
Palo Alto, CA 94306
Tel. 650-833-4240 | Fax 650-833-4226

Updated 6/26/2017