FRIENDSHIP SCHOOL

525 Third Street, Imperial Beach CA 91932 (858) 298-2213 FAX (619) 423-6007

AUTHORIZATION FOR OTHER SPECIALIZED HEALTH CARE SERVICES – SKIN INTEGRITY

Name of student: _____ Date of birth:_____ Age: _____

I, the undersigned, as the physician for the above-named student, do recommend and approve the following procedure to be provided to this pupil during school hours:

1. Name and description of procedure(s):
   Skin Integrity

2. The procedure(s) is (are) to be provided according to the following time schedule or PRN:
   PRN

3. Please check one item and sign the attached procedure:
   ☐ I have reviewed the procedure found on Friendship School's website. *http://www.sdcoe.net/ssp/speced/friendship/?loc=parent*
   ☐ I have reviewed and approved the attached procedure with my modifications, which I have noted.
   ☐ I have attached my recommendations or orders for the procedure.

4. Please list any signs or symptoms that may indicate an emergency situation. List the emergency procedures. (Attach additional page if necessary)

5. I understand that the procedures:
   - Must be ones that can be learned in a reasonable amount of time
   - Should not require the presence of a physician, medical judgment based on extensive medical training, or a undue amount of time to be provided or performed
   - Must be provided or performed during the school day so that the pupil can attend school or benefit from this or her educational program
   - Must be ordered by a licensed physician and surgeon

6. The medical justification for providing the procedure(s) during school hours is:

_____

Signature of Physician **NPI #** **Date**

_____

Address **Telephone**

We understand that the school administrator will appoint a qualified designated person(s) who, in accordance with *Education Code* Section 49423.5, will be performing the health care service listed above *and that any nonlicensed qualified designated person(s) who performs the service will do so under the supervision of a qualified school nurse, public health nurse, or qualified licensed physician and surgeon.* We understand that in performing this service, the designated person(s) will be using a procedure that has been approved by our physician.

_____

Signature of Parent/Guardian **Date**