

FRIENDSHIP SCHOOL

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



AUTHORIZATION FOR MULTIPLE POSITIONS WHILE AT SCHOOL

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:

Due to the nature of this student's disability, it is understood that s/he will be positioned at school in the following equipment to facilitate classroom participation and position changes will occur every 2 hours throughout the school day:

- Classroom Chair
 - Floor sitter with casters locked or unlocked
 - Positioning chair with supports and tray
 - Wheelchair with or without tray
 - Platform bed
- Recliner
- Bean Bag with positioning pillows
- Floor mat
- Side lying/Prone over wedge

****If this student has additional positioning equipment such as a gait trainer or stander, an additional letter will be required from the physician clearing him/her to use this equipment at school. Please specify if the student must wear AFOs, SMOs or other orthoses while using a gait trainer or stander. Include letter with this authorization.**

Specialized instructions: _____

*If student has surgery/significant medical status change, this form must be updated with the school nurse. If this information is not updated, the school will not be held responsible for any new medical information not shared.

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