PHYSICIAN'S AUTHORIZATION FOR SPECIAL HEALTH CARE

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN AND PHYSICIAN

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE. **Parent/Legal Guardian is encouraged to participate in the development of an Individual Health Care Plan if needed.**

Student Name: Last	First	M.I.	Sex ❑ M ❑ F	DOB:	Grade:	School Year:

I hereby request that the treatment specified below be performed on my child.

Parent or Legal Guardian Name (print) _____ Parent/Legal Guardian's Signature _____ Date _____

PART 2: PHYSICIAN TO COMPLETE.

❑ **PHYSICAL CONDITION FOR WHICH THE STANDARDIZED PROCEDURE IS TO BE PERFORMED**

_____

_____

_____

❑ **NAME OF STANDARDIZED PROCEDURE**

- ❑ catheterization
- ❑ oxygen
- ❑ gastrostomy care
- ❑ tracheostomy care
- ❑ suctioning
- ❑ Other _____
- ❑ blood glucose monitoring

Check one:

- ❑ I reviewed and approved the attached standardized procedure as written.
- ❑ I reviewed and approved the attached standardized procedure with the attached modifications.
- ❑ I do not approve of the school's standardized procedure and therefore, have attached my alternate written recommendations.

❑ **PRECAUTIONS, POSSIBLE UNTOWARD REACTIONS, AND INTERVENTIONS**

_____

_____

_____

❑ **TIME SCHEDULE AND/OR INDICATION FOR THE PROCEDURE**

_____

_____

_____

❑ **THE PROCEDURE IS TO BE CONTINUED AS ABOVE UNTIL:**

_____
(Date)

PHYSICIAN SIGNATURE

Physician Name (print) _____ Physician's Signature _____ Date _____

Address _____ Telephone _____ Fax _____

RETURN COMPLETED FORM TO SCHOOL NURSE/HEALTH OFFICE AS SOON AS POSSIBLE