FRIENDSHIP SCHOOL

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

AUTHORIZATION FOR ORAL AND NASAL SUCTIONING

AUTORIZACIÓN PARA ASPIRACIÓN ORAL Y NASAL

Nombre del estudiante: _____ Fecha de nacimiento: _____ Edad: _____

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):

   _____

   _____

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

Entendemos que el administrador de la escuela nombrará a una persona designada calificada que, de acuerdo con la Sección 49423.5 del Código de Educación, realizará el servicio de atención médica mencionado anteriormente y que cualquier persona designada calificada sin licencia que realice el servicio lo hará por lo tanto, bajo la supervisión de una enfermera escolar calificada, una enfermera de salud pública o un médico y cirujano licenciado calificado. Entendemos que al realizar este servicio, la(s) persona(s) designada(s) utilizará(n) un procedimiento que ha sido aprobado por nuestro médico.

_____

Signature of Parent/Guardian **Date**