PHYSICIAN'S AUTHORIZATION FOR SPECIAL HEALTH CARE PROCEDURE IN SCHOOL

Student: ____School:____________________________________

Date of Birth: ____________________ Grade: __________Teacher/ID#: ________________________________

Name of special health care procedure: ____

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Physical condition for which procedure is to be performed: ____

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Special precautions, possible untoward reactions, and interventions: ____________________________________

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Time scheduled/indication for the procedure: ____

____

End date for procedure (unless specified, will expire at end of school year): ______________________________

____ ________________________________
Physician's Signature Date

____ ________________________________
Clinic Name/Address Phone

I hereby request that the treatment specified above be performed for the above-named child.

____ ________________________________
Parent/Guardian Signature Date