PARENT AUTHORIZATION
FOR SPECIALIZED HEALTH CARE

We (I), the undersigned, who are the parents/guardians of

____ ________________________
Name Date of Birth

Request that the following health care service(s) ____________________________________

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be administered to our child. We understand that qualified designated person(s) will perform the above-mentioned health care service. It is our understanding that in performing this service, the designated person(s) will use a standardized procedure that has been approved by our physician.

Physician ______________________________________ Tel _____________________

Address ____

City/State/Zip ____

We will notify the school immediately if the health status of ___________________________ changes, if we change physicians, or if there is a change or cancellation of the procedure.

Parent(s) ____

Address ____

City/State/Zip ____

Tel Numbers ____________________ ______________________ ____________________
Home Work Cell

____________________ ______________________ ____________________
Home Work Cell

Signature of Parents/Guardians____

Date__________________________