Deer Valley School District
Physician's Authorization for Medical Procedure at School

School Year _____

☐ Catheterization ☐ Central Line ☐ Ostomy Care ☐ Tracheostomy Other _____

Parent Consent for Release of Information or Medical Records

To Whom It May Concern:

I hereby give my permission for exchange of confidential information contained in the record of my child to school personnel.

Name of Child/Student _____ DOB: _____

Please list names of medical providers, phone and/or fax numbers and address:

_____

_____

_____ _____

Signature of Parent/Guardian **Date**

Note to medical provider: *Special Health Care procedures administered at school must be ones that can be learned in a reasonable amount of time. Some procedures may be performed by unlicensed, parent designated school personnel.* **Please attach any specific care plans. Use 1 for per procedure.**

Physician: Please complete and return to the School Nurse

1. Diagnosis/physical condition that necessitates procedure (s). Please include IDC-10 code.

   _____

2. Medical procedures and equipment needed: _____

   _____

3. Time scheduled for procedure: _____

4. Please list any emergency procedure: _____

5. List any concerns about transporting the student on the bus: _____

6. Should P.E./sports be restricted? _____

7. Length of day that student can tolerate? _____

8. What are the risks for this student coming to school? (Exposure to childhood diseases, etc.)

   _____

9. Does this student require special infection control procedures? _____
   MRSA/ Pseudomonas positive? YES NO Other: _____

Signature of Physician _____ Date: _____

Print name of Physician _____ Address: _____

Physician Phone Number _____

Please return to: _____ _____
Nurse School

Nurse Phone _____ Nurse FAX _____