FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT
520 Fifth Ave. Fairbanks, AK 99701 (907) 452-2000
www.k12northstar.org

REQUEST FOR SPECIALIZED NURSING SERVICE

Name_____Birthdate_____Grade_____

School_____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Physical condition _____

Name of the standardized procedure_____

Time (s) of procedure _____ Discontinue on_____

Physician_____Phone _____

Physician Signature _____ Date _____

Parent/Guardian Authorization

1. I request that the above specialized procedure(s) be done during school hours as ordered by my child's physician/licensed prescriber. I also request the health care procedure(s) be given on field trips, as prescribed.
2. I will notify the school of any change in the procedure(s), (i.e., change in time or amount, procedure is stopped, etc.).
3. I give permission for the procedure(s) to be given by school personnel as delegated, trained, and supervised by the school nurse.
4. Legally, I may refuse to sign for the treatment. If I refuse to sign, school personnel (including the school nurse) will not be able to provide the treatment at school.
5. This consent may be revoked at any time, by sending a written notice to the licensed school nurse.

NOTE: All supplies must be provided by parent/guardian **Permission for Release of Information**

6. I give permission for the school nurse to consult with my child's physician/licensed prescriber about any questions regarding the prescribed procedure(s) or medical condition(s) related to the procedure(s).
7. I give permission for the Physician/ Licensed prescriber to release information related to the above procedure(s) and medical condition(s) to the licensed school nurse.

Parent/Guardian Signature_____Date _____

FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Ave. Fairbanks, AK 99701

(907) 452-2000

REQUEST FOR SPECIALIZED NURSING SERVICE

Name _____ Date of Birth _____

School _____ Grade _____School Year _____

TO BE COMPLETED BY PHYSICIAN

Physical condition _____

Name of the standardized procedure _____

Time (s) of procedure _____ Discontinue on _____

Physician _____ Phone_____

Physician Signature _____ Date _____

Parent/Guardian Authorization

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