STATE OF LOUISIANA
PHYSICIAN'S AUTHORIZATION FOR SPECIAL HEALTH CARE
TO BE COMPLETED BY PARENT/LEGAL GUARDIAN AND PHYSICIAN

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE.
Parent/Legal Guardian is encouraged to participate in the development of an Individual Health Care Plan if needed.

Student Name: Last First M.I.	Sex ❑ M ❑ F	DOB:	Grade:	School Year:

I hereby request that the treatment specified below be performed on my child.

_____ _____ _____
Parent or Legal Guardian Name (print) Parent/Legal Guardian's Signature Date

PART 2: PHYSICIAN TO COMPLETE.

❑ **PHYSICAL CONDITION FOR WHICH THE STANDARDIZED PROCEDURE IS TO BE PERFORMED**

_____
_____
_____

❑ NAME OF STANDARDIZED PROCEDURE

❑ catheterization ❑ oxygen ❑ gastrostomy care
❑ tracheostomy care ❑ suctioning ❑ Other _____
❑ blood glucose monitoring

Check one:

❑ I reviewed and approved the attached standardized procedure as written.
❑ I reviewed and approved the attached standardized procedure with the attached modifications.
❑ I do not approve of the school's standardized procedure and therefore, have attached my alternate written recommendations.

❑ PRECAUTIONS, POSSIBLE UNTOWARD REACTIONS, AND INTERVENTIONS

_____
_____
_____

❑ TIME SCHEDULE AND/OR INDICATION FOR THE PROCEDURE

_____
_____
_____

❑ THE PROCEDURE IS TO BE CONTINUED AS ABOVE UNTIL:

_____
(Date)

PHYSICIAN SIGNATURE

_____ _____
Physician Name (print) Physician's Signature Date

_____ _____ _____
Address Telephone Fax

RETURN COMPLETED FORM TO SCHOOL NURSE/HEALTH OFFICE AS SOON AS POSSIBLE