Pickerington Schools

Request for Specialized Health Care Services
Physician Authorization

Dear Physician:

Your patient, _____, residing at _____

and born _____ is attending Pickerington Schools.

The parent or guardian of this student is requesting that specific health care procedures be provided while the student is at school. We are requesting your assistance in identifying the health information and services that need to be provided in the school setting. We look forward to working with you to provide an appropriate and safe educational experience for your patient.

Procedure:

- ☐ I have reviewed and approved the attached procedure as written.
- ☐ I have reviewed and approved the attached procedure with my written modification.
- ☐ Please contact me to discuss this matter prior to my reviewing and/or approving any procedures.

Other Recommendations:

Please include time, schedule, duration of treatment, any special precautions or possible reactions, and interventions.

_____

_____

Physician Authorization:

Provider signature: _____ Date: _____

Provider name: _____ Phone: _____

Address: _____