Cherokee County School District

# PARENT AND PHYSICIAN REQUEST FOR SPECIALIZED HEALTHCARE PROCEDURE

Student _____ D.O.B. _____

School _____ Teacher _____ Grade _____

Parent/Legal Guardian _____

Phone: Home _____ Work _____ Cell _____

Diagnosis: _____

Procedure: _____

_____

_____

_____

I am requesting that the above specialized healthcare procedure be available to my child and be performed by the school nurse or designated school personnel, in accordance with the physician's orders (attached). I understand that I must provide all equipment/supplies needed for the above listed procedure. I understand that I will be given the opportunity to participate in the training of school personnel. I also understand that the school nurse and/or designated school personnel will not be permitted to perform such services until the appropriate forms have been completed and received and any necessary training has been completed.

*If the requested forms and training are not complete prior to my child attending school, I will be available to provide these services at school.*

I, _____ , give authorization to the school nurse or designated school personnel to perform or assist my child with the above procedure. I authorize the physician's office to release confidential information about my child. Additionally, I hereby release CCSD school personnel from responsibility for any complications resulting from the administration of this procedure.

_____ _____

Parent / Legal Guardian's Signature Date

_____

I am requesting and giving authorization for designated school personnel to perform or assist my patient with the above specialized healthcare procedure. I have also completed the necessary action plan which includes individualized physician's orders to meet my patient's needs.

Procedure may be done by: Teacher ☐ Nurse ☐ Paraprofessional ☐ Other ☐
*(Parent will provide supplies/equipment.)*

_____ _____

Physician's Signature Date

_____ _____

Physician's Printed Name Physician's Phone Number