PHYSICIAN'S AUTHORIZATION FOR SPECIAL HEALTH CARE

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN AND PHYSICIAN

Part 1: CONTACT INFORMATION						
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. I understand trained, unlicensed personnel may perform the procedure/treatment.

_____ _____ _____

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 (Include ICD-10 Code):

_____

_____

NAME OF STANDARDIZED PROCEDURE: Please use a separate form for each procedure.

❑ Catheterization: Type/Size of Catheter: _____ Lubricant (if any): _____

Cleaning Solution: _____ ❑Betadine ❑Wipes ❑Other_____

❑ Gastrostomy Care: Formula _____ Amount _____ Flush Amount _____

❑ Suctioning: Type: ❑ Oral/ Pharyngeal ❑ Trach

Equipment: ❑ Bulb Suction ❑ Yankauer ❑ Suction Catheter

❑ Tracheostomy care: Type/Size Trach_____

❑ Oxygen: Amount:_____ ❑ Nasal Cannula ❑Type Mask_____

❑ Blood Glucose Monitoring

❑ Other _____

TIME SCHEDULE AND/OR INDICATION FOR THE PROCEDURE:

_____

PRECAUTIONS, POSSIBLE UNTOWARD REACTIONS, AND INTERVENTIONS:

_____

_____

THE PROCEDURE IS TO BE CONTINUED AS ABOVE UNTIL: ❑ End of Session or until_____

(Date)

_____ _____ _____ _____

Physician Name (print) Physician's Signature NPI # Date

_____ _____ _____

Address Phone # Fax #

RETURN COMPLETED FORM TO SCHOOL NURSE AS SOON AS POSSIBLE