



ESCAMBIA COUNTY PUBLIC SCHOOLS
Health Services
J. E. Hall Center, 30 E. Texar Dr.
Pensacola, FL 32503
Phone: 469-5456

AUTHORIZATION FOR HEALTH PROCEDURE/TREATMENT

THIS FORM IS VOID IF ALTERED IN ANY WAY

INSTRUCTIONS: Each section must be completed by the appropriate person as follows: Parts I and III by Parent/Guardian, Part II by Physician. Please return the completed form to the school health room/office.

Student's Name (Last, First, Middle)	Birth Date	Allergies	Grade/Homeroom Teacher
Parent/Guardian	Address		
Phone	Work Phone	other Phone (cellular phone, beeper, etc.)	

II. TREATMENT PLAN (To Be Completed By Prescribing Physician).

This request is to be effective for the school year 20____-20____ or Earlier Stop Date: _____

Diagnosis: _____ Procedure/Treatment: _____

Time schedule for Procedure/Treatment: _____

Student specific instructions for Procedure/Treatment: _____

Student specific Precautions, Possible Complications, and Recommended Intervention(s):

Print Physician's Name	Physician's Address	Phone
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Physician's Signature: _____

Date: _____

III. PARENTAL PERMISSION (To Be Completed By Parent/Guardian).

I hereby request the school's personnel, or its agents to provide the above prescribed procedure or treatment. I give permission for my child to receive this procedure/treatment while in school or while participating in school activities away from the school site. I understand that there is no liability on the part of the school district, its personnel, or its agents for civil damages as a result of the administration of the procedure/treatment to my child when the person performing the procedure/treatment acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and school health personnel of the Escambia County Public Schools or its agents.

Parent/Guardian Signature: _____

Date: _____