

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	DOB:	Grade:	School Year:
				<input type="checkbox"/> M <input type="checkbox"/> F			

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
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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