Elementary School 704-717-7550
Middle School 704-595-9452
Fax number 704-717-7558 (Fax)

PHYSICIAN AND PARENT AUTHORIZATION TO PROVIDE SPECIALIZED HEALTH CARE PROCEDURE

Form Valid from: (date)_____ to/through:_____
(unless earlier date is specified above, all forms become invalid at end of school year)

Student Name:_____ Date of Birth:_____ Current School Grade:_____

1. Physical condition for which the specialized health care procedure is to be performed:

2. Name of procedure(s) (e.g., catheterization, gastrostomy feeding, suctioning) to be provided:

3. Precautions, possible untoward reactions and interventions:

4. Time schedule and/or indication for the procedure:

5. The procedure is to be continued as above until: (date)

Ordering Physician
I hereby request school staff to perform the above procedure on or for the above-named student.

Physician's Signature:	**Date:**
Physician's Name:	**Phone #:**
Address:	

Parent/Guardian Authorization/Agreement:

- The above health care procedure(s) has been prescribed by a licensed physician and, as the parent/guardian of child (named above), I request that procedure(s) be administered.
- I understand that the school nurse or other qualified designated person(s) will be performing the health care service. It is my understanding that, in performing the service, the designated person(s) will be using a standardized procedure, which has been approved by our physician.
- I will furnish all equipment needed for the procedure to be performed and restock equipment as needed. I understand that all equipment must be labeled with the my child's name.
- I will notify the school immediately if the health status of my child changes, we change physicians, or there is a change or cancellation of the procedure.
- I understand that the above procedure should be scheduled before or after school hours whenever possible.
- As the parent/guardian of this child, I assume the responsibility of any adverse reaction or result from my child receiving this health care procedure and I, hereby, release the Board of Directors, School Administration and employees from all liability.
- If needed, I give permission for the school to fax this form to my child's healthcare provider. I give permission for my child's healthcare provider to fax this form back to the school. I understand the school cannot guarantee the confidentiality of the fax machine.

Parent/Guardian Signature:		**Date:**
Parent/Guardian Name:		
Address:		
Home Phone #:	**Work #:**	**Mobile #:**

Approved by Executive Director:	*Date:*
Reviewed by School Nurse:	*Date:*