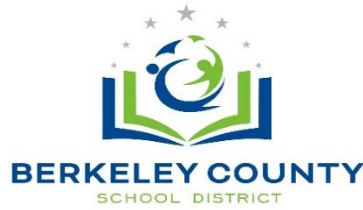

PHYSICIAN'S AUTHORIZATION
FOR SPECIALIZED PHYSICAL HEALTH CARE
PROCEDURES ADMINISTERED DURING SCHOOL HOURS

Dear Physician,

In order for the school to provide the services needed by this student, we must have written orders on file from the student's physician for any procedure to be performed during school hours. These orders must be on file prior to the student receiving the services.

Name of Student:____ Birth Date:_________________

Home Address:____

1. Physical condition for which the procedure is to be performed:____
   ____
2. Procedure is vital to the health of this child and must be done during school hours: ☐ Yes ☐ No
3. Name of standardized procedure____
   ____
4. Precautions, possible untoward reactions and interventions:____
   ____
5. Time schedule and/or indication for the procedure:____
   ____
6. Procedure is to be continued as above until:____
   ____
7. Procedure may be performed by:____
   ☐ RN
   ☐ LPN
   ☐ Trained Personnel

Physician Signature:____ Date:______________________

Physician Address:____ Phone:_____________________

I hereby request the treatment specified above be performed to the above named child.

Parent/Guardian Signature:_______________________________________ Date:______________________

Revised 2017