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 the procedure/treatment may be performed by trained, unlicensed personnel.

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:

_____

_____

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_____ Amount Flush_____

❑ 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 _____ Date _____

Address _____ Phone _____ Fax _____

RETURN COMPLETED FORM TO SCHOOL NURSE AS SOON AS POSSIBLE