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

Name of Student: _____ Birth Date: _____

1. Physical condition for which the standardized procedure is to be performed.
   _____
2. Name of Procedure*:* _____
3. Precautions, possible untoward reactions, and interventions:
   _____
   _____
   _____
   _____
4. Time schedule and/or indication for the procedure:
   _____
   _____
5. The procedure is to be continued until: (Date) _____

_____ _____
Physician's Signature Date

_____ _____
Physician's Address Phone

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

Parent/Guardian Name (Please Print): _____

Signature of Parent/Guardian: _____ Date: _____

Rev. 2/14/19