

Port Edwards School

AUTHORIZATION FOR SPECIAL HEALTH CARE PROCEDURES

Student: _____ Birthdate: _____

School Year: _____ School: _____ Grade: _____

Parent(s)/Guardian(s): _____

Phone: (Home) _____ (Work) _____

I request that, during school hours, my son/daughter receive the special health care service(s) authorized by his/her physician.

I will be responsible for:

- 1) delivering necessary equipment and supplies to school
- 2) maintaining a sufficient amount of supplies
- 3) keeping school staff informed of changes in health status, procedure or physician
- 4) **completing new forms when changes occur**

I hereby release the Board of Education and its agents and employees from any and all liability that may result from my child receiving the authorized special health care service(s).

Parent/Guardian signature

Date

PHYSICIAN AUTHORIZATION

_____ requires the following procedure during school hours:
(Patient's Name)

Name of procedure: _____

Frequency of procedure: _____

Specific time of procedure: _____

Specific details (e.g. name/amount of formula, amount of water, catheter size, etc.):

I agree to be available for contact with the school district nurse regarding this request.

Physician Name: _____ Phone: _____
(Please print)

Physician's Signature: _____ Date: _____
(No stamp)