Washington County School District Health Services

MEDICAL PROCEDURE AUTHORIZATION

STUDENT:	SCHOOL:	GRADE:	DOB:
ADDRESS:		STATE:	ZIP:
MEDICAL HISTORY:			

TO BE FILLED OUT OR REVIEWED BY THE PRESCRIBING PRACTITIONER:

Medical Procedure_____

Medical Procedure_____

Medical Procedure_____

PRESCRIBING PRACTITIONER AUTHORIZATION: *I have determined that the above described medical procedure is medically necessary during school hours to maintain this child's physical health.*

Comments: _____

_____

Practitioner Signature:_____ **Date:**_____
Office Phone: _____ **Fax Number:** _____

PARENT/GUARDIAN AUTHORIZATION*:* *The school authorized personnel has my permission to administer the above Medical Procedure. I will also adhere to the following conditions of this agreement:*

1. I will bring this form into the office completed and signed by my health practitioner before expecting this medical procedure to be completed at school.
2. I understand that school personnel may not perform the medical procedure until training by the school nurse is completed.
3. I will maintain the supplies needed for this procedure throughout the year
4. I will renew this authorization every time there is a change of any kind regarding the medical procedure.

Parent/Guardian Signature:_____ **Date:** _____

Home Phone: _____ **Emergency Phone:**_____

3/2015