SAMPLE

AUTHORIZATION TO ADMINISTER SPECIALIZED HEALTH SERVICE

All specialized health services/procedures will be administered by a licensed school nurse or other qualified school personnel who have been trained by the school nurse to administer the service/procedure under indirect supervision of the school nurse. The purpose of this policy is to ensure that students receive necessary therapeutic intervention according to their physician's orders while ensuring maximum safety for all concerned.

Student's Name: ____

Date of Birth: ______________________ School: ____

PHYSICIAN'S STATEMENT

NAME OF SERVICE/PROCEDURE: ____

TIME/FREQUENCY OF ADMINISTRATION: ____

SPECIAL INSTRUCTIONS AND CONDITIONS OF ADMINISTRATION: _____________________________________

SYMPTOMS OF ADVSERSE EFFECTS:____

____

Will special or adapted procedure of administration be needed? ________ If yes, explain:

Physician's Signature: _________________________________ Printed Name: ________________________________

Address: ____

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PARENT/GUARDIAN STATEMENT

I/We, the undersigned parent(s)/guardian(s) of _____________________________,hereby request the school nurse or designee to administer the above procedure according to physician's instructions.
I/we agree to furnish all equipment, supplies, medication, formulas or other items necessary for the administration of the service/procedure and to provide replacement and maintenance as necessary. We agree to notify the school nurse immediately if there is any change in the student's status or physician's orders.

Parent/Guardian Signature: ____ Date: ___________

Parent/Guardian Signature: ____ Date: ___________

Home Phone:________________________________ Work Phone: ___________________________

(02/1998)