NORWALK PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES

Authorization for Specialized Health Care Procedure

Physician's Order Date: _____

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____

Condition for which specialized health care is to be performed:

_____

Special health care procedure:

_____
_____
_____

Time and/or indication for procedure:

_____
_____

Precautions, possible untoward reactions, and interventions:

_____
_____

Procedure to be administered from _____ to _____

_____ _____ _____
Physician Signature Stamp Phone Number

Authorization by Parent/Guardian:

I hereby request that the above treatment be administered by school personnel. I give my permission for the school nurse to communicate with the authorized prescriber as necessary to ensure the safe administration of the procedure.

I agree to notify the school nurse if the health status of my child changes, if the physician changes, or if the procedure is modified or discontinued.

_____ _____ _____
Parent/Guardian Signature Date

_____
Phone Number

Rev. 5/19/11