Houston County School District

Health Related Services

Physician's Authorization For Having Specialized Physical Health Care Service Procedures Administered

Name of Student: ______________________________ Student ID #: _______________

DOB: ________________________________ School: ___________________________

1. Physical condition/Diagnosis for which the specialized procedure is to be performed:

   ____

2. Name of specialized procedure: ____

3. Special Instructions for procedure: ____

   ____

   ____

4. Can the student perform the procedure independently? Y _____ N _____

5. Precautions, possible untoward reactions, and interventions: _______________________

   ____

6. Time schedule and/or indication for the procedure: ___________________________

   ____

7. Can the parent/guardian make adjustments to procedure: Y___ N ____.

   If yes, Please explain ____

   ____

8. The procedure is to be continued as above until: ______________________

   Date

______________________________ ______________________

Physician's Signature Date

______________________________ ______________________

Address Telephone

I hereby request that the procedure/treatment specified be performed to the above named student. I have reviewed the procedure with the school staff and provided demonstration and evaluation. I understand this procedure may be performed by unlicensed school personnel.
I will provide all necessary supplies/equipment and restock as needed.

____ ______________________

Signature of Parent/Guardian Date

(478) 988-6200, Ext: 3554

Houston County Board of Education
High-Achieving Students

Fax: (478) 328-1407

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