Santa Maria Joint Union High School District

2560 SKYWAY DRIVE - SANTA MARIA CA 93455
TEL: (805) 922- 4573 - FAX: (805) 928-9916

Parent's Request for Specialized Physical Health Care Services Provided
School Year _____

Specialized Physical Health Care Service

[ ] Gastrostomy/Jejunostomy [ ] VNS [ ] Oral Suction [ ] catheterization [ ] Tracheostomy

[ ] Mechanical Ventilation [ ] Oxygen Administration [ ] Central Venous Catheter [ ] Diastat

We (I), the undersigned, the parent (s)/guardian(s) of _____ Date of birth _____
(Name of Student)

Request that the following specialized physical health care service be administered to our child in accordance with ***Education Code 49423.5***. We understand that the school administrator will appoint a qualified designated person(s) who, in accordance with **Education Code Section 49423.5**, will be performing the health care service listed above and ***that any non-licensed qualified designated person(s) who performs the service will do so under the supervision of a qualified school nurse, public health nurse, or qualified licensed physician and surgeon,***

We understand that in performing this service, the designated person(s) will be using a procedure that has been approved by my child's physician.

Name of Physician: _____ Phone: _____

Address: _____
(Street) (City) (Zip Code)

We understand that we are responsible for providing and bringing all necessary supplies and equipment, correctly labeled, with proper direction for use at school.

We will notify the school immediately if our child's health status changes, change in physicians, or procedure change or canceled. We understand that a written order from the physician, as listed above, to be provided for any change in procedure.

We understand that the specialized physical health care services are provided within school hours.

The school is authorized to provide emergency medical services for my child whenever the need for such services is deemed necessary. The school cannot accept a "do nothing" or "no code" authorization.

My signature below provide authorization for the above written orders. I understand that all procedure will be implemented in accordance with state laws and regulations. I understand the unlicensed designated school personnel under the training and supervision provided by the school nurse may perform specialized physical healthcare services.

This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization.

Parent(s)/Guardian(s) Signature(s):

Print Name: _____ Signature: _____ Date: _____

Print Name: _____ Signature: _____ Date: _____