Houston County School District Authorization for Specialized Procedures at School (HRS 31)

Name of Student: _____ Date of Birth: _____

Allergies: _____ School: _____

----------TO BE COMPLETED BY PHYSICIAN: Fax to (478) 328-1407----------

1. Diagnosis or physical condition for which the specialized procedure is to be performed:

   _____

2. Name of specialized procedure: _____
3. Instructions for procedure: _____

   _____

   _____

4. Can the student perform the procedure independently? Yes ____ No____
5. Precautions, possible reactions, interventions: _____

   _____

6. Time schedule and/ or indication for procedure: _____
7. Can the parent/ guardian make adjustments to procedure? Yes ____ No____

   If yes, please explain (time, amount, etc.): _____

   This procedure is to be continued as above until: _____

   Physician's Signature: _____ Date: _____

   Print Physician Name: _____ NPI: _____

----------TO BE COMPLETED BY PARENT/ GUARDIAN----------

As parent or guardian of the above-named student, I request that the procedure specified above be performed to the above-named student. I have reviewed the procedure with the school staff and provided demonstrations and evaluations. I understand this procedure may be performed by unlicensed school personnel. I understand that I must provide all necessary supplies/ equipment and will restock as needed.

Signature of Parent/ Guardian: _____ Date: _____

Print Name: _____ Phone: _____

School Nurse Signature: _____ Date: _____