Every child. Every day.
Mooresville
GRADED SCHOOL DISTRICT

PHYSICIAN AND PARENT AUTHORIZATION FOR PHYSICAL HEALTH CARE PROCEDURE AT SCHOOL

Name of Student: _____ Birth Date: _____

In order to keep this child in optimal health and to maintain maximum school performance, it is necessary that a prescribed treatment/procedure be given during school hours.

1. Physical condition for which the specialized physical health care procedure is to be preformed:

_____

2. Name of procedure (i.e. catheterization, gastrostomy tube feeding, suctioning) to be provided:

_____

3. Precautions, possible untoward reactions, and interventions: _____

_____

4. Time schedule and/or indication for the procedure: _____

5. The procedure is to be continued as above: ___ throughout the school year or until _____
Date

_____ _____
Physician's Signature **Date**

_____ _____
Address Telephone

I hereby request that the procedure specified above be performed on or for the above named child.

_____ _____
Parent/Guardian Signature **Date**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize _____ to release to the school nurse or
Physician's Name
Principal specific, confidential, medical information contained in his/her record about my child. This information will be used by school staff to deliver health care services to my child in school.

_____ _____ _____
Child's Name **Birth Date** **Parent/Guardian Signature** **Date**