

Authorization to Administer a Specialized Health Care Procedure

All Specialized Health Care Procedures/services (SHCP) will be administered by a licensed Nurse or other qualified school personnel who have been trained by the District Nurse to administer the service/procedure under the indirect supervision of the District Nurse.

Student Name: _____ DOB: _____ School: _____ Grade: _____
Parent Name: _____ Phone #: _____
Address: _____

To Be Completed by Physician

1. Diagnosis: _____

2. Name/description of SHCP: _____

3. Time schedule and/or indications of SHCP: _____

4. Precautions to consider and action needed: _____

This procedure is valid for one calendar year from the date below.

Physician Signature: _____ Date: _____
Address: _____ Phone #: _____

Parent/Guardian Consent

I/We, the undersigned parent(s)/guardian(s) request the District Nurse or designee to administer the above procedure according to the provider's instructions. I/We agree to furnish all equipment, supplies, medication, formulas, or other necessary items for the administration of the service or procedure and to provide replacement and maintenance as necessary. I/We agree to notify the District Nurse immediately if there is any change in the student's status or provider orders. **Implementation of these orders includes authorization to contact the healthcare provider to discuss elements of care needed for this procedure. Without this authorization these orders will not be implemented.**

Parent Signature: _____ Phone: _____ Date: _____

District Nurse Signature: _____ Date: _____