## Washington County School District Health Services

## **MEDICAL PROCEDURE AUTHORIZATION**

STUDENT:	SCHOOL:	GRADE:	DOB:
ADDRESS:		STATE:	ZIP:
MEDICAL HISTORY:		I	
TO BE FILLED OUT OR REVIEW	ED BY THE PRESC	CRIBING PRACTITIONE	CR:
Medical Procedure			
Medical Procedure			
Medical Procedure			
PRESCRIBING PRACTITIONER AUTHORIZATION: I have determined that the above described medical procedure is medically necessary during school hours to maintain this child's physical health.  Comments:			
Practitioner Signature:			
Office Phone:	Fa	nx Number:	
PARENT/GUARDIAN AUTHORIZA administer the above Medical Procedur			
<ol> <li>I will bring this form into the office completed and signed by my health practitioner before expecting this medical procedure to be completed at school.</li> <li>I understand that school personnel may not perform the medical procedure until training by the school nurse is completed.</li> <li>I will maintain the supplies needed for this procedure throughout the year</li> <li>I will renew this authorization every time there is a change of any kind regarding the medical procedure.</li> </ol>			
Parent/Guardian Signature:		I	Oate:
Home Phone:	Emerg	ency Phone:	

3/2015