FINAL 11/06

STATE OF LOUISIANA

PHYSICIAN'S AUTHORIZATION FOR SPECIAL HEALTH CARE

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN AND PHYSICIAN

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE. **Parent/Legal Guardian is encouraged to participate in the development of an Individual Health Care Plan if needed.**

Student Name: Last First M.I.	Sex ☐ M ☐ F	DOB:	Grade:	School Year:

I hereby request that the treatment specified below be performed on my child.

Parent or Legal Guardian Name (print) ____________ Parent/Legal Guardian's Signature ____________ Date ____________

PART 2: PHYSICIAN TO COMPLETE.

☐ **PHYSICAL CONDITION FOR WHICH THE STANDARDIZED PROCEDURE IS TO BE PERFORMED**

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☐ **NAME OF STANDARDIZED PROCEDURE**

☐ catheterization ☐ oxygen ☐ gastrostomy care

☐ tracheostomy care ☐ suctioning ☐ Other ____________

☐ blood glucose monitoring

Check one:

☐ I reviewed and approved the attached standardized procedure as written.

☐ I reviewed and approved the attached standardized procedure with the attached modifications.

☐ I do not approve of the school's standardized procedure and therefore, have attached my alternate written recommendations.

☐ **PRECAUTIONS, POSSIBLE UNTOWARD REACTIONS, AND INTERVENTIONS**

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☐ **TIME SCHEDULE AND/OR INDICATION FOR THE PROCEDURE**

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☐ **THE PROCEDURE IS TO BE CONTINUED AS ABOVE UNTIL:**

____
(Date)

PHYSICIAN SIGNATURE

Physician Name (print) ____________ Physician's Signature ____________ Date ____________

Address ____________ Telephone ____________ Fax ____________

RETURN COMPLETED FORM TO SCHOOL NURSE/HEALTH OFFICE AS SOON AS POSSIBLE