

**SAMPLE**

**AUTHORIZATION TO ADMINISTER SPECIALIZED HEALTH SERVICE**

All specialized health services/procedures will be administered by a licensed school nurse or other qualified school personnel who have been trained by the school nurse to administer the service/procedure under indirect supervision of the school nurse. The purpose of this policy is to ensure that students receive necessary therapeutic intervention according to their physician's orders while ensuring maximum safety for all concerned.

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ School: \_\_\_\_\_

PHYSICIAN'S STATEMENT

NAME OF SERVICE/PROCEDURE: \_\_\_\_\_

TIME/FREQUENCY OF ADMINISTRATION: \_\_\_\_\_

SPECIAL INSTRUCTIONS AND CONDITIONS OF ADMINISTRATION: \_\_\_\_\_

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SYMPTOMS OF ADVSERSE EFFECTS: \_\_\_\_\_

Will special or adapted procedure of administration be needed? \_\_\_\_\_ If yes, explain:

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Physician's Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

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**PARENT/GUARDIAN STATEMENT**

I/We, the undersigned parent(s)/guardian(s) of \_\_\_\_\_, hereby request the school nurse or designee to administer the above procedure according to physician's instructions.

I/we agree to furnish all equipment, supplies, medication, formulas or other items necessary for the administration of the service/procedure and to provide replacement and maintenance as necessary. We agree to notify the school nurse immediately if there is any change in the student's status or physician's orders.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_