

OXNARD UNION HIGH SCHOOL DISTRICT

ACHS 389-6402	CIHS 484-6321	FHS 394-4760	HHS 3852753	OHS 278-2929	PHS 278-5008	RCHS 394-4760	RMHS 278-5519
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Health Services

Parent's Request for Having Specialized Physical Health Care Services Provided

We (I), the undersigned, the parent(s)/guardian(s) of _____
(Student) *(Birthdate)*

request that the following specialized physical health care service be administered to our child in accordance with *Education Code* Section 49423.5. We understand that the school administrator will appoint a qualified designated person(s) who, in accordance with *Education Code* Section 49423.5, will be performing the health care service listed above *and that any nonlicensed qualified designated person(s) who performs the service will do so under the supervision of a qualified school nurse, public health nurse, or qualified licensed physician and surgeon.*

We understand that in performing this service, the designated person(s) will be using a procedure that has been approved by our physician:

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(Name of physician) *(Telephone number)*

(Street) *(City)* *(State)* *(ZIP code)*

We understand that we are responsible for providing and bringing all necessary supplies and equipment, correctly labeled, with proper directions for use at school.

We will notify the school immediately if our child's health status changes, we change physicians, or the procedure is changed or canceled. We understand that any change in procedures must be received in writing from the physician listed above.

We understand that, whenever possible, the specialized physical health care service must be provided before or after school hours.

The school is authorized to provide emergency medical services for my child whenever the need for such services is deemed necessary. The school cannot accept a "do nothing" or "no code" authorization.

Signature of:

(Parent/Guardian) *(Date)*

(Street) *(City)* *(State)* *(ZIPcode)*

Telephone (Work):_() _____ ()

Telephone (Home):_() _____ ()
(Fa/her/Guardian) *(Mother/ Guardian)*