OXNARD UNION HIGH SCHOOL DISTRICT

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

Health Services

Request for Physician's Authorization for Specialized Physical Health Care Services Performed at School

Name of pupil: _____ Birth date: _____

Dear Dr. _____

The parent or guardian of the pupil listed above has requested that a specialized physical health care se1vice be performed at school. Please complete the "Physician's Authorization" on the back of this form as soon as possible and return it to the school address given below. For this procedure to be performed at school, you must verify that it cannot be scheduled for other than during school hours.

You must realize that the individual performing the procedure may or may not be a licensed registered nurse. The school administrator has the authority to designate another school employee to perform such services. In addition, the classroom personnel have other children for whom they are responsible.

If you believe that the specialized physical health care service must be performed by licensed personnel, please indicate this information on the back of this form.

The child may need to be transported a long distance to and from school, and the only caretaker may be the bus driver. Several children may be on the bus. If you feel that this situation is inappropriate for the child, please indicate this information on the back of this form.

Please notify the school immediately if the order for the procedure(s) changes or if you are no longer treating this pupil. For your convenience, a sample copy of the procedure has been attached for your review.

Thank you for your prompt attention to this matter. Please be advised that the service cannot be provided until your orders have been received.

_____

(Signature of parent) *(Date)* *(Telephone number)*

Parent's Authorization for Exchange of Information

To Whom It May Concern:

I hereby give my permission for the exchange of confidential information contained in the record of my child:

_____

(Name) *(Birth date)*

between _____ and _____

(Name of physician) *(Name of school district)*

_____

Parent/Guardian *(Date)*

Please return to: _____

Physician's Authorization

Name of pupil: Birth date:

Address:

(Street) *(City)* *(Stale)* *(ZIP code)*

I, the undersigned, as the physician for the above-named student, do recommend and approve the following procedure(s) to be provided to this pupil during school hours:

1. Name and description of procedure(s):

2. The physical condition(s) of this pupil is (are):

3. The procedure(s) is (are) to be provided according to the following time schedule or PRN (as necessary):

and should be continued until:

4. Please check one item and sign the attached procedure:

D a. I have reviewed and approved the attached procedure as written.
D b. I have reviewed and approved the attached procedure with my modifications, which I have noted.
D c. I have attached my recommendations or orders for the procedure.

5. Please list any signs or symptoms that may indicate an emergency situation. List the emergency procedures.

6. List any concerns about transporting the student on the school bus.

7. I understand that the procedures:

a. Must be ones that can be learned in a reasonable amount of time
b. Should not require the presence of a physician, medical judgement based on extensive medical training, or an undue amount of time to be provided or performed
c. Must be provided or performed during the school day so that the student can attend school or benefit from his or her educational experience
d. Must be ordered by a licensed physician or surgeon

8. The medical justification for providing the procedure(s) during school hours is:

Signature of physician:

Address: *(Date)* ( ) *(Telephone number)*

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