STATE OF LOUISIANA
PHYSICIAN'S AUTHORIZATION FOR SPECIAL HEALTH CARE

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN AND PHYSICIAN

Part 1: CONTACT INFORMATION							
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.
I understand that the procedure specified below may be performed by trained, unlicensed school personnel.

______________________ 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: (Please complete the attached physician order form).

❑ catheterization ❑ gastrostomy care ❑ tracheostomy care ❑ suctioning

❑ oxygen ❑ blood glucose monitoring ❑ Other ______________________

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 Name (print)

______________________ Physician's Signature

________ Date

______________________ Address

________ Phone

________ Fax

RETURN COMPLETED FORM TO SCHOOL NURSE AS SOON AS POSSIBLE