

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	DOB:	Grade:	School Year:
				<input type="checkbox"/> M			
				<input type="checkbox"/> F			

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
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PART 2: PHYSICIAN TO COMPLETE.

PHYSICAL CONDITION FOR WHICH THE STANDARDIZED PROCEDURE IS TO BE PERFORMED

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

TIME SCHEDULE AND/OR INDICATION FOR THE PROCEDURE

THE PROCEDURE IS TO BE CONTINUED AS ABOVE UNTIL:

(Date)

PHYSICIAN SIGNATURE

Physician Name (print)	Physician's Signature	Date
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Address	Telephone	Fax
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RETURN COMPLETED FORM TO SCHOOL NURSE/HEALTH OFFICE AS SOON AS POSSIBLE