"We Inspire and Empower Learners"

NORTH ROYALTON CITY SCHOOLS

REQUEST FOR HEALTH CARE SERVICES

Student Name _____ **Date** _____

School Grade Date of Birth

Physician's Order for Specialized Health Care Procedure (must be completed annually): Back Side of Form Must Also Be Completed by Parent

HEALTH CARE PROCEDURES

Condition for which procedure is required _____

_____

Description of procedure (s) _____

_____

_____

Precautions and possible adverse reactions and interventions _____

_____

_____

Time schedule and suggested environment for procedure (s) _____

_____

_____

The procedure is to be continued as above until (date) _____

_____

Activity limitations _____

_____

_____ _____
Physician's Signature Address

_____ _____
Physician's Printed Name Telephone

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PARENT AUTHORIZATION

FOR SPECIALIZED HEALTH CARE SERVICE

We (I), the undersigned, who are the parents/guardians of:

_____ _____
Name Date of Birth

Request that the following health care services (s) _____

_____

_____

be administered to our child. We understand that qualified designated person(s) will perform the above-mentioned health care services. It is our understanding that in performing this service, the designated person(s) will use a standardized procedure that has been approved by our physician.

Physician _____ Telephone _____

Address _____

City/State/Zip_____

We understand and will notify the school immediately if my child's health status changes, if we change physicians, or if there is a change or cancellation of the procedure.

Parent(s)_____

Address_____

City/State/Zip_____

Telephone _____ _____ _____
Home Work Cell

Signature of Parents/Guardians _____

Date _____