BEAVERCREEK CITY SCHOOL DISTRICT
3040 Kemp Road, Beavercreek, OH 45431

School Health Services

AUTHORIZATION FOR ADMINISTRATION OF SPECIALIZED HEALTH CARE PROCEDURES

Students who need specialized health care procedures during the school day must have, in writing, a physician's prescription and parental authorization.

Name of Student _____ DOB _____

Parent's Name _____ Phone _____

Address _____ Zip _____

Diagnosis _____

Name of Procedure _____

_____

Treatment Prescription _____

Description of the Procedure _____

_____

_____

Time/Interval Procedure is to be Done _____

_____

Amount - (If Applicable) _____

Precautions and/or possible adverse reactions _____

_____

_____

Discontinuation Date _____

Authorization for this procedure is required annually.

Physician Name _____ Date _____
(Signature)

_____ Phone _____
(Type or Print Name)

Address _____

_____

I hereby give my permission for my child to receive the specialized procedure named above as prescribed by my child's physician.

Date _____ Signature _____
(Parent/Guardian)

Date _____ Signature _____
(School Nurse)