CENTRAL VALLEY
SCHOOL DISTRICT #356

Parent Authorization for Specialized Health Care Services

I, the undersigned, the parent/guardian of: _____
(Student Name) (Birthdate)
request that the following health care service(s):_____

_____

_____

_____be administered to my child by Central Valley School District personnel. This treatment/procedure must be performed during school hours to enable _____ to attend school. It is my understanding that the persons designated to perform this service may, depending upon the circumstances, be non-medical personnel who will be trained and supervised by the School Nurse. I will supply any necessary equipment ready for use.

I have obtained detailed written instructions from _____, the health care provider (HCP) who recommended this service. These are attached. Authorization for school district personnel to communicate with the HCP is also attached.

I understand service will not be started until these orders are on file in my child's school and adequate training of staff has been completed.

I will notify the school immediately if the health status of _____ changes, we change physicians, or there is a change or cancellation of the procedure.

_____ _____ _____
Date Signature of Parent/Guardian Telephone Number

Copies: Confidential Health File
Parent