CENTRAL VALLEY
SCHOOL DISTRICT #356

Health Care Provider's (HCP) Authorization for Specialized Health Care Services

Student Name:_____ **Birthdate**: _____

School:_____ **Grade**: _____

The parent/guardian of the above named student has requested the school district to provide special health care services at school. If it is **essential** that this treatment/procedure be given during school hours, please complete the form below:

TREATMENT/PROCEDURE: _____

_____

- Time treatment/procedure is to be performed:_____
- Specific instructions for treatment/procedure:_____

  _____

  _____

  _____
- Possible hazards and danger signals; emergency care which may need to be provided:

  _____

  _____
- Special equipment or environment recommended (parent is to supply equipment ready for use):

  _____
- Duration of order (not to exceed one school year):_____
- I am willing to participate in any necessary training of school staff members with regards to this treatment/procedure. ❑ Yes ❑ No

I will assist in helping to determine that adequate, safe arrangements are made for performance of this treatment/procedure. I may be called by school personnel regarding this treatment/procedure.

_____ **X**_____

Date of Signature HCP's Signature

Telephone Number:_____ Name: _____

(Print or type)