Akron Children's Hospital
School Health Services

Authorization for Specialized Health Care Procedures

Students who need specialized health care procedures during the school day must have a doctor's prescription/order and parental permission.

Name of Student _____ Date of Birth_____

School _____Grade/Teacher _____

Parent/Guardian _____ Phone _____

Address _____Phone _____

Diagnosis_____

Procedure & Instructions: _____

_____

_____

Precautions/Potential Adverse Reactions: _____

_____

_____

Physician Signature _____

Physician Name (Print): _____

Address: _____ Phone: _____

I give permission for my child to receive the specialized procedure described above as prescribed by his/her doctor. I give my permission for designated school personnel to assist my child or to perform the specialized procedure as ordered by the doctor.

Date _____ Parent Signature: _____

THIS FORM EXPIRES AT THE END OF THE SCHOOL YEAR