

PHYSICIAN'S AUTHORIZATION FOR SPECIALIZED PHYSICAL HEALTH CARE SERVICES

Ventura County SELPA

Name of Student: _____

D.O.B.: _____

Address: _____
(Street) (City) (State) (Zip code)

I, the undersigned, as the physician for the above-name student, do recommend and approve the following procedure(s) to be provided to this pupil during school hours:

1. Name and description of procedure(s):

2. The physical condition(s) of this pupil is (are):

3. The procedure(s) is (are) to be provided according to the following time schedule or PRN (as necessary):

and should be continued until:

4. Please check one item and sign the attached procedures:

a. I have reviewed and approved the attached procedure as written

b. I have reviewed and approved the attached procedure with my modifications, which I have noted.

c. I have attached my recommendations or orders for the procedure.

5. Please list any signs of symptoms that may indicate an emergency situation. List the emergency procedures.

6. List any concerns about transporting the student on the school bus.

7. I understand the procedures:

a. Must be ones that can be learned in a reasonable amount of time

b. Should not require the presence of a physician, medical judgment based on extensive medical training, or an undue amount of time to be provided or performed

c. Must be provided or performed during the school day so that the pupil can attend school or benefit from his or her educational program

d. Must be ordered by a licensed physician and surgeon

8. The medical justification for providing the procedure(s) during school hours is:

Signature of physician

(Date)

()

(Telephone number)

Address

(Street)

(City)

(State)

(Zip code)

Health Care Procedures attached