



Physician Authorization for Special Health Care Needs

Student Name: _____ D.O.B.: _____

Physical condition/diagnosis for which procedure is to be performed:

Procedure to be performed:

Time schedule and/or indication for the procedure:

Procedure to continue for the following time frame/dates:

Precautions/ possible adverse reactions related to procedure:

Above procedure to be performed by:

Physician's signature

Date

Printed Physician's name

Phone

.....
I hereby request the procedure specified above be performed to the above named child.

Parent/Guardian signature

Date

Print Name