

## STATE OF LOUISIANA

## PHYSICIAN'S AUTHORIZATION FOR SPECIAL HEALTH CARE

**TO BE COMPLETED BY PARENT/LEGAL GUARDIAN AND PHYSICIAN**

<b>PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE.</b> Parent/Legal Guardian is encouraged to participate in the development of an Individual Health Care Plan if needed.							
Student Name:	Last	First	M.I.	Sex	DOB:	Grade:	School Year:
				<input type="checkbox"/> M <input type="checkbox"/> F			
I hereby request that the treatment specified below be performed on my child.							
_____			_____			_____	
Parent or Legal Guardian Name (print)			Parent/Legal Guardian's Signature			Date	
<b>PART 2: PHYSICIAN TO COMPLETE.</b>							
<input type="checkbox"/> <b>PHYSICAL CONDITION FOR WHICH THE STANDARDIZED PROCEDURE IS TO BE PERFORMED</b>							
_____ _____ _____							
<input type="checkbox"/> <b>NAME OF STANDARDIZED PROCEDURE</b>							
<input type="checkbox"/> catheterization		<input type="checkbox"/> oxygen		<input type="checkbox"/> gastrostomy care			
<input type="checkbox"/> tracheostomy care		<input type="checkbox"/> suctioning		<input type="checkbox"/> Other _____			
<input type="checkbox"/> blood glucose monitoring							
Check one:							
<input type="checkbox"/> I reviewed and approved the attached standardized procedure as written.							
<input type="checkbox"/> I reviewed and approved the attached standardized procedure with the attached modifications.							
<input type="checkbox"/> I do not approve of the school's standardized procedure and therefore, have attached my alternate written recommendations.							
<input type="checkbox"/> <b>PRECAUTIONS, POSSIBLE UNTOWARD REACTIONS, AND INTERVENTIONS</b>							
_____ _____ _____							
<input type="checkbox"/> <b>TIME SCHEDULE AND/OR INDICATION FOR THE PROCEDURE</b>							
_____ _____ _____							
<input type="checkbox"/> <b>THE PROCEDURE IS TO BE CONTINUED AS ABOVE UNTIL:</b>							
_____ (Date)							
<b>PHYSICIAN SIGNATURE</b>							
_____			_____			_____	
Physician Name (print)			Physician's Signature			Date	
_____			_____			_____	
Address			Telephone			Fax	

**RETURN COMPLETED FORM TO SCHOOL NURSE/HEALTH OFFICE AS SOON AS POSSIBLE**