BLOOMSBURY ELEMENTARY SCHOOL
Health Office
(908) 479-4414 ext. 210

HEALTHCARE PROVIDER'S AUTHORIZATION FOR HAVING SPECIALIZED PHYSICAL HEALTH CARE SERVICE PROCEDURES ADMINISTERED

Student Name: _____ Birth Date: _____

Address: _____

1. Physical condition for which the standardized procedure is to be performed:

_____

2. Name of standardized procedure:

_____

3. Precautions, possible untoward reactions, and interventions:

_____

_____

4. Time schedule and/or indication for the procedure:

_____

5. The procedure is to be continued as above until:

_____
Date

_____ _____
Healthcare Provider Signature Date

_____ _____
Healthcare Provider Address Telephone

I hereby request that the treatment specified be performed to the above-named child.

_____ _____
Parent/Guardian Signature Date