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 healthcare providers prescription/order and parental permission.

Name of Student _____ Date of Birth_____

School _____Grade/Teacher _____

Parent/Guardian _____ Phone _____

Address _____

Diagnosis_____

Procedure & Instructions: _____

_____

_____

Precautions/Potential Adverse Reactions: _____

_____

_____

Healthcare Provider Signature _____

Healthcare Provider Name (Print): _____ Phone: _____

Address: _____

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

_____ _____

Parent Name (print) Signature Date

THIS FORM EXPIRES AT THE END OF THE SCHOOL YEAR