Reset Form

North Mason School District

71 E. Campus Drive, Belfair, WA 98528

(360) 277-2300 (360) 277-2320 FAX

HEALTH CARE PROVIDER AUTHORIZATION FOR SPECIALIZED HEALTH CARE SERVICES

Student Name: _____ Birthdate: _____

School: _____ Grade/Teacher: _____ **Section 504 Plan** ☐ **IEP** ☐

The parent/guardian of the above named student has requested the school district to provide special health care services at school. If it is **essential** that this treatment/procedure be given during school hours, please complete the form below:

TREATMENT/PROCEDURE:

_____

Time treatment/procedure is to be performed: _____

Specific instructions for treatment/procedure:

_____

Possible hazards and danger signals; emergency care which may need to be provided:

_____

Special equipment or environment recommended (parent is to supply equipment ready for use):

_____

Duration of order (not to exceed one school year): _____

I am willing to participate in any necessary training of school staff members with regards to this treatment/procedure. Yes ◯ No ◯

I will assist in helping to determine that adequate, safe arrangements are made for performance of this treatment/procedure. I may be called by school personnel regarding this treatment/procedure.

Name: _____ Telephone Number (Print or type) _____

X_____

Physician's/Dentist's Signature Date of Signature _____