Reset Form

North Mason School District

71 E. Campus Drive, Belfair, WA 98528
(360) 277-2300 (360) 277-2320 FAX

PARENT AUTHORIZATION FOR SPECIALIZED HEALTH CARE SERVICES

I, the undersigned, the parent/guardian of: _____ _____
(Student Name) (Birthdate)

request that the following health care service/procedure(s):

_____

be administered to my child by North Mason School District personnel. This treatment/procedure must be performed during school hours to enable my child to attend school. It is my understanding that the persons designated to perform this service may, depending upon the circumstances, be non-medical personnel who will be trained and supervised by the School Nurse. **I will supply any necessary equipment ready for use.**

I have obtained detailed written instructions from _____, the physician/dentist who recommended this service. These are attached. Authorization for school district personnel to communicate with the physician/dentist is also attached.

I understand service will **not** be started until these orders are on file in my child's school and adequate training of staff has been completed.

I will notify the school immediately if the health status of my child changes, we change physicians, or there is a change or cancellation of the procedure.

_____

Date Signature of Parent/Guardian Telephone Number

Care plans are provided to staff on a need to know basis
Copy to Confidential Health File
Copy to Parent

☐ Parent ☐ Trans ☐ Nurse ☐ Teacher ☐ PE ☐ SPEC ☐ HRA ☐ Kitchen ☐ Sec- Principal