Galt Joint Union Elementary School District

1018 C Street, Suite 210, Galt, CA 95632
209-744 4545 * 209-744-4553 fax

Parent's Request for Having Specialized Physical Health Care Services Provided

We (I), the undersigned, the parent(s)/guardian of ____,

(Name of Pupil) (Birth Date)

request that the following specialized physical health care service be administered to our child in accordance with *Education Code Section* 49423.5. We understand that the school administrator or designee will appoint a qualified designated person(s) who, in accordance with *Education Code Section* 49423.5, will be performing the health care service listed above and that any *non-licensed qualified designated person(s) who performs the service will do so under the supervision of a qualified school nurse, public health nurse, or qualified physician and surgeon.*

We understand that in performing this service, the designated person(s) will be using a procedure that has been approved by our physician:

____( )________________

(Name of Physician) (Telephone Number)

____

(Street) (City) (State) (Zip Code)

We understand that we are responsible for providing and bringing all necessary supplies and equipment, correctly labeled, with proper directions for use at school.

We will notify the school immediately if our child's **health status changes**, we change physicians, or the procedure is changed or cancelled. We understand that any change in the procedures must be received in writing from the physician listed above.

We understand that, whenever possible, the specialized physical health care service must be provided before or after school hours.

The school is authorized to provide emergency medical services for my child whenever the need for such services is deemed necessary. The school cannot accept a "do nothing" or "no code" authorization.

Signature of:

____

(Parent/Guardian) (Date)

Address:

____

(Street) (City) (State) (Zip code)

Telephone (Work): ( )____( )______________________________________

Name of pupil: ____ Birth date: __________________________________

Dear Dr. ______________________________________

The parent/guardian of the pupil listed above has requested that a specialized physical health care service be performed at school. Please complete the "*Physician's Authorization*" on the next page as soon as possible, and return it to the school address given below. For this procedure to be performed at school, you must verify that it cannot be scheduled for other than during school hours.

You must realize that the individual performing the procedure may or may not be a licensed registered nurse. The school administrator or designee has the authority to designate another school employee to perform such services. In addition, the classroom personnel have other children for whom they are responsible. If you believe that the specialized physical health care service must be performed by licensed personnel, please indicate this information on this form.

Please notify the school immediately if the order for the procedure(s) changes or if you are no longer treating this pupil. Thank you for your prompt attention to this matter. Please be advised that the service cannot be provided until your orders have been received.

(Signature of parent) (Date) (Telephone number)

Parent's Authorization for Exchange of Information

To Whom It May Concern:

I hereby give my permission for the exchange of confidential information contained in the record of my child:

(Name) (Birth date)

Between ____ and ____
(Name of Physician) (Name of School District)

____
(Signature of parent/guardian)

Please return to: ____
(School Nurse/Principal)

____
(Name of School) (Address) (City) (State) (Zip code)

Physician's Authorization

Name of pupil: Birth date:

(Address) (Street) (City) (State) (Zip code)

I, the undersigned, as the physician for the above-named student, do recommend and approve the following procedure(s) to be provided to this pupil during school hours:

1. Name and description of procedure(s):

____

2. The physical condition(s) of this pupil is (are):

____

3. The procedure(s) is (are) to be provided according to the following time schedule or PRN (as necessary):

____

4. Please check one item and sign:
   - o I have reviewed and approved the attached procedure as written.
   - o I have reviewed and approved the attached procedure with my modifications, which I have noted.
   - o I have attached my recommendations or orders for the procedure.

5. Please list any signs or symptoms that may indicate an emergency situation. List the **emergency** procedure:

____

6. List any concerns about transporting the student on the school bus.

____

7. I understand that the procedures:

   - Must be ones that can be learned in a reasonable amount time.
   - Should not require the presence of a physician, medical judgment based on extensive medical training, or an undue amount of time to be provided or performed.
   - Must be provided or performed during the school day so that the pupil can attend school or benefit from his/her educational program.
   - Must be ordered by licensed physician and surgeon.

8. The medical justification for providing the procedure(s) during school hours is:

____

____

Signature of physician

____( )________________

Address (Street) (City) (State) (Zip code) (Date) (Telephone number)