



**THE SCHOOL DISTRICT OF GREENVILLE COUNTY
AUTHORIZATION FOR MEDICAL PROCEDURES AT SCHOOL**

*****MUST BE SIGNED BY LEGAL GUARDIAN AND PHYSICIAN*****

STUDENT'S NAME: _____ BIRTH DATE: _____

LEGAL GUARDIAN: _____ DAYTIME PHONE: _____

PHYSICIAN TREATING STUDENT FOR THIS CONDITION: _____

PROCEDURE: _____

STUDENT'S PRIMARY DIAGNOSIS THAT REQUIRES THIS PROCEDURE:

SPECIFIC INSTRUCTIONS FROM THE PHYSICIAN FOR THIS PROCEDURE (LIST ANY PRECAUTIONS OR SIDE EFFECTS AS WELL):

TIME SCHEDULE AND/OR INDICATIONS FOR THIS PROCEDURE: _____

THIS PROCEDURE SHOULD BE DONE BY:

- NURSE NURSE AND STUDENT STUDENT ALONE

DATE TO **START** PROCEDURE: _____ DATE TO **STOP** PROCEDURE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

I understand that I must provide all equipment and supplies in order for my child to complete this procedure at school. I also understand that I must notify the school immediately if the health status of my child changes, if we change physicians, or if the procedures are changed or cancelled. I understand that whenever possible this procedure will be provided at home before or after school hours. I hereby give my permission for the exchange of confidential information between the above named physician and the school.

LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

BOTH AREAS MUST BE SIGNED BY THE PHYSICIAN AND PARENT IF THE STUDENT IS TO SELF-ADMINISTER THIS PROCEDURE DURING SCHOOL HOURS.

This child must be allowed to self administer and self monitor this procedure without School District guidance while at school. The physician and parent have determined this will provide the best medical treatment for this child. He/she has been trained by the physician and has demonstrated competency in this procedure. I realize that the School District of Greenville County can not be held responsible for any adverse outcome of this action.

Physician Signature: _____ Date: _____

Legal Guardian Signature: _____ Date: _____