DEPARTMENT OF HUMAN SERVICES
SCHOOL HEALTH SERVICES
ARLINGTON, VIRGINIA

Authorization for Specific Medical Procedures
Physician's Order

Name of Child_____Date_____

Address_____ Date of Birth_____

Condition for which specific medical procedure is to be performed:_____

_____

Name of specific medical procedure:_____

Special orders: (attached protocol may be accepted or adapted as needed. Alternatively, a specific order may be written)

_____

Precautions, possible adverse reaction, interventions:_____

_____

_____

Material/Equipment to perform special procedure:_____

Specific medical procedure is to be performed as above_____
Date

to_____ at _____.
Date Time (s)

Physician's Signature_____ Address_____

Telephone_____

Authorization of Parent/Guardian

for the Specific Medical Procedure to be Performed in the School Setting

To: Department of Human Services/Arlington Public Schools

Date:_____

I hereby request that staff provide my child_____the specific medical procedures as ordered above by his/her physician. I understand that the Department of Human Services and Arlington Public Schools or its personnel will not be responsible for complications relating to or arising from this procedure.

_____ _____
Telephone (Home) Parent/Guardian (Signature)

_____ _____
Telephone (Work/Emergency) Witness (Signature)