



Beaumont Unified School District Health Services

Authorization for Specialized Physical Health Care

SECTION I - To be completed and signed by attending licensed physician or surgeon

NAME OF PUPIL (LAST NAME, FIRST NAME, MIDDLE NAME)	SEX () Male () Female	DATE OF BIRTH (MO/DAY/YEAR)
ADDRESS OF PUPIL (NUMBER, STREET, CITY, ZIP CODE)	TELEPHONE NUMBER ()	
PHYSICAL CONDITION FOR WHICH STANDARDIZED PROCEDURE IS TO BE PERFORMED		
NAME OF STANDARDIZED PROCEDURE		
Check and initial one of the following statements: 1. () ____ I have reviewed and approved the attached standardized procedure as written. 2. () ____ I have reviewed and approved the attached standardized procedure with the attached modification. 3. () ____ I do not approve the school's standardized procedure and, there, have attached my alternative written recommendations.		
PRECAUTIONS, POSSIBLE UNTOWARD REACTIONS, INTERVENTIONS		
TIME SCHEDULE AND/OR INDICATION FOR THIS PROCEDURE		
Procedure above requires annual review and authorization of attending licensed physician and surgeon. Any changes in procedure prior to annual review require written recommendation of attending licensed physician or surgeon.		
TYPE OR PRINT NAME OF ATTENDING LICENSED PHYSICIAN OR SURGEON	TELEPHONE NUMBER ()	
ADDRESS OF ATTENDING LICENSED PHYSICIAN OR SURGEON (NUMBER, STREET, CITY, ZIP CODE)		
SIGNATURE OF ATTENDING LICENSED PHYSICIAN OR SURGEON DATE SIGNED / /		

SECTION II – PARENTAL REQUEST / AUTHORIZATION

To be completed by parent or legal guardian and submitted to school administration.

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

In accordance with California law, I request that my child,

_____ given the specialized physical health care service by qualified persons designated by the school administrator, and by use of a standardized procedure which has been approved by our attending licensed physician and surgeon. I will notify the school immediately if there is a change in my child's health status, procedure, or if we change physicians, and I will keep emergency medical care information up-to-date for school personnel. I will comply with the school's policies and procedures, and I understand that whenever possible, the specialized health care service should be provided before or after school hours.

SIGNATURE OF PARENT / LEGAL GUARDIAN (SPECIFY RELATIONSHIP
TO PUPIL)

TELEPHONE
NUMBER
()

DATE SIGNED