FONTANA UNIFIED SCHOOL DISTRICT
COMPREHENSIVE HEALTH SERVICES
Fontana, California

PHYSICIAN'S AUTHORIZATION FOR SPECIALIZED PROCEDURES

Name of Pupil:_____ D.O.B.: _____

Address:_____City_____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 the attached procedure:

- ☐ I have reviewed and approved the attached procedure as written.
- ☐ I have reviewed and approved the attached procedure with my modifications, which I have noted.
- ☐ I have attached my recommendations or order for the procedure.

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

_____

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

_____

7. I understand that the procedure:

   a. Must be ones that can be learned in a reasonable amount of time.
   b. 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.
   c. Must be provided or performed during the school day so that the pupil can attend school or benefit from his or her educational program.
   d. Must be ordered by a licensed physician and surgeon.

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

_____

Physician's Signature:_____Date:_____

Address_____City_____Zip_____

H-77
7/2012

Office Stamp Required: