ST. LUCIE PUBLIC SCHOOLS
9461 Brandywine Lane, Port St. Lucie, FL 34986
772-429-4570

PHYSICIAN AUTHORIZATION FOR SCHOOL TREATMENT/PROCEDURE

PART I (to be completed by physician) Date _____

Student's name _____ ICD-9 diagnosis code _____

Treatment/Procedure needed: _____
What time/times of the school day is this procedure needed: _____
Please describe the procedure including and special equipment to be used and any special considerations:

_____

_____

_____

_____

Please list any precautions and/or emergency signs and symptoms to watch for and recommended interventions:
_____

_____

_____

_____
Physician's signature

_____
Phone number

PART II (to be completed by parent/guardian)

I hereby request and give permission for my child to be given the above treatment/procedure while in school. I will notify the school immediately if the health status of my child changes or there is a change in the treatment/procedure. I understand that if there is special equipment or supplies needed to perform this treatment, it will be maintained by me, delivered to the school in good working condition daily, and that school personnel will assume no responsibility for the maintenance and/or delivery of this special equipment/supplies.

_____ _____
Parent/guardian signature Date

_____ _____
Principal's signature Date

_____ _____
School nurse signature Date