



SPECIFIC HEALTH CARE PROCEDURES AUTHORIZATION

FAIRFAX COUNTY HEALTH DEPARTMENT

PART 1: PARENT TO COMPLETE

Student Name:	Last	First	M.I.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB	Grade	Year
Home Phone	Father Work Phone			Mother Work Phone			

PART 2: PHYSICIAN TO COMPLETE

Physical condition for which the specific procedure is to be performed

Name of specific procedure

Check one:

- I reviewed and approved the attached standardized procedure as written.
- I reviewed and approved the attached standardized procedure with the attached modifications.
- I do not approve of the school's standardized procedure and, therefore, have attached my alternate written recommendations.

Precautions, possible adverse reactions

Time to be given at school and/or indications for the procedure. Please check box for duration.

Current school year _____ OR Effective date _____ to _____

If procedure requires medication, complete Medication Authorization form

Student is to self administer the procedure:

NO

YES I believe that this student has received adequate instruction on how and when perform this procedure, and that he/she can do the procedure independently.

Physician Information

(Print Physician's Name)

(Print Address)

(Physician's Signature)

(Telephone)

(Date)

PART 3: DISCLOSURE AND PERMISSION. Parent/Guardian to Complete and Sign.

1. I hereby acknowledge that this medical information will be shared only with appropriate school staff members.
2. I hereby request that identified members of the school staff of _____ school be caretakers of medication, supplies, and equipment and administrators of specific procedure(s) for the student named above, as ordered by our physician.
3. I hereby authorize Fairfax County Public Schools (FCPS) and Fairfax County Health Department (FCHD) personnel to facilitate the procedure or medication directed by this authorization. I agree to release, indemnify, and hold harmless FCPS and FCHD and any of their officers, staff members, or agents from lawsuit, claim, expense, demand, or action, etc., against them for assisting this student with the use of medication or procedure, provided FCPS and FCHD staff members comply with the physician or parent or guardian orders set forth in accordance with provisions of the current version of Regulation 2104. No School Board employee, school public health nurse, or clinic room aide shall facilitate the use of medication or procedure as an exception under School Board policy, unless all the required clearances have been personally reviewed by the principal or his or her designee.
4. I give permission to contact the above named physician provider to clarify information provided on the authorization should the need arise.

(Parent/Guardian Signature)

(Date)

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent or of the eligible student.