ST. JOHNS COUNTY SCHOOL DISTRICT

HEALTH SERVICES

MEDICAL PROCEDURE AUTHORIZATION

Student Name: _____ Date of Birth: _____
School: _____ Teacher/Grade: _____

The parents of _____ _____
(name of student) (date of birth)

have requested the St. Johns County School District to perform the following procedure for their child at school:

_____
(PROCEDURE)

Please provide the following information:

Order and special guidelines, type and amount of water, formula, etc. Other special recommendations:

_____

_____

_____

_____

These procedures and orders will be renewed annually or more frequently if applicable.

Physician's Name: _____ Address: _____
Phone Number: _____ Fax Number: _____

Nursing services are recommended for the care of this student during the school day.

Physicians Signature: _____ **Date:** _____