AUTHORIZATION FOR HEALTH CARE PROCEDURES
To be completed by Parents/Guardians

Student's Name:_____ Birth date:_____

Address:_____

School:_____ Date:_____

I hereby request and authorize that my child receive at school, the health care procedures as described by our doctor and/or health care practitioner. The administration of such health care procedures are to be the responsibility of the principal or his or her designate.

This authorization is considered valid until _____ (no later than June 30 next following this date) unless withdrawn by the doctor, health care practitioner or parent.

We understand and agree that the Division agrees to perform the necessary procedure in exchange for this release from liability. We understand that the medical procedure will not be performed by a medical professional.

Further, we agree that we will keep the Division apprised of any changes in medical procedure(s) to be performed.

_____ _____

Signature of Witness Signature of Parent/Guardian

_____ _____

Date Date

Adopted September 1, 2009		