Dare County Department of Health & Human Services
School Health Program

Health Care Provider and Parent Authorization for Provision of Specialized Health Care Service
(new form must be completed every school year)

Return completed form to:

_____
School Nurse School

_____
Address Zip Fax Number

Name of Student:_____Date of Birth_____

1. Condition for which the specialized nursing procedure is to be performed:
   _____
2. Name of procedure (e.g., catheterization, gastrostomy feeding, suctioning) to be provided:
   _____
3. Precautions, possible reactions, and interventions:
   _____
4. Time scheduled and/or indication for the procedure:
   _____
5. The procedure is to be continued as above until:_____(date)

_____
Health Care Provider's Signature

_____ Stamp
Date

_____
Phone Number

I hereby request that the procedure specified above be performed on or for the above named child.

_____ _____
Parent/Guardian's Signature Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize _____to release to the school nurse
(Health Care Provider's name)
specific, confidential, medical information contained in his/her record about my child. This information will be used by the school nurse and school staff to deliver health care services to my child in school.

_____ _____
Student's Name Date of Birth

To: _____ _____ _____
Name of School Date Parent/Guardian's Signature

7/16