DEPARTMENT OF HUMAN SERVICES
SCHOOL HEALTH SERVICES
ARLINGTON, VIRGINIA

Authorization for Specific Medical Procedures
Physician's Order

Name of Child____Date______________

Address____ Date of Birth_______________

Condition for which specific medical procedure is to be performed:________________________

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Name of specific medical procedure:____

Special orders: (attached protocol may be accepted or adapted as needed. Alternatively, a specific order may be written)

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Precautions, possible adverse reaction, interventions:____________________________________

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Material/Equipment to perform special procedure:______________________________________

Specific medical procedure is to be performed as above__________________________________
Date

to__________________________ at _______________________.
Date Time (s)

Physician's Signature_________________________________ Address___________________

Telephone___________________

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Authorization of Parent/Guardian

for the Specific Medical Procedure to be Performed in the School Setting

To: Department of Human Services/Arlington Public Schools

Date:________________________

I hereby request that staff provide my child___________________________________the specific medical procedures as ordered above by his/her physician. I understand that the Department of Human Services and Arlington Public Schools or its personnel will not be responsible for complications relating to or arising from this procedure.

____________________________ ________________________________
Telephone (Home) Parent/Guardian (Signature)

____________________________ ________________________________
Telephone (Work/Emergency) Witness (Signature)