Fairview Park City School District

21620 Mastick Rd., Fairview Park, OH 44126 P: (440) 331-5500 • F: (440) 356-3545
Keith Ahearn, Superintendent • Rob Showalter, Treasurer
MS/HS Clinic Fax: (440) 356-3529 • **Gilles-Sweet Clinic Fax:** (440) 356-3701 • **EEC Clinic Fax:** (440) 356-3544

REQUEST FOR HEALTH CARE SERVICES

Student _____ Date _____

Address City/State/Zip

Physician's Order For Specialized Health Care Procedure

THE PHYSICIAN'S ORDER SHOULD BE UPDATED AT LEAST ANNUALLY.

HEALTH CARE PROCEDURES

Condition for which procedure is required _____

_____

_____

Description of standardized procedure(s) (Add pages or procedure if needed) _____

_____

_____

Precautions and possible adverse reactions and interventions _____

_____

_____

Time schedule and suggested environment for procedure(s) _____

_____

_____

The procedure is to be continued as above until (date) _____

_____

Dietary recommendations _____

_____

_____

Activity limitations _____

_____

_____

_____ _____
Physician's Signature Date Tel

_____ _____
Parent Signature Tel

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PARENT AUTHORIZATION
FOR SPECIALIZED HEALTH CARE

We (I), the undersigned, who are the parents/guardians of

_____ _____
Name Date of Birth

Request that the following health care service(s) _____

_____

_____

_____

_____

be administered to our child. We understand that qualified designated person(s) will perform the above-mentioned health care service. It is our understanding that in performing this service, the designated person(s) will use a standardized procedure that has been approved by our physician.

Physician _____ Tel _____

Address _____

City/State/Zip _____

We will notify the school immediately if the health status of _____ changes, if we change physicians, or if there is a change or cancellation of the procedure.

Parent(s) _____

Address _____

City/State/Zip _____

Tel Numbers _____ _____ _____
Home Work Cell

_____ _____ _____
Home Work Cell

Signature of Parents/Guardians _____

Date _____