School District of Oconee County

Physician's Authorization for Special Medical Procedures

FULL NAME OF STUDENT: _____ Birth date: _____

School: _____ Grade: _____ Teacher: _____

Physical Condition for which the special medical procedure is to be performed: _____

_____

Name of special medical procedure: _____

_____

Instructions (if needed) for the special medical procedure: _____

_____

_____

Precautions, possible untoward reactions: _____

_____

Recommended interventions: _____

_____

Time schedule and/or other indications for the implementation of the special medical procedure:

_____

The special medical procedure is to be continued as above until: _____

_____

Physician's Signature: _____ Date: _____

Physician's Address: _____

Telephone: _____

Attachment: Permission for Release of Information