Muskingum County
Board of Developmental Disabilities

Dream ★ Believe ★ Achieve

PHYSICIAN'S AUTHORIZATION / REQUEST FOR HEALTH CARE SERVICES

Student Name___________________________________ Date of Birth___________________

Address____

Grade/Classroom_______________________Allergies____________________________________

The Above Student is Under My Care and Should Receive:

Prescribed Procedure/Treatment (please include: time, schedule, and/or duration of treatment)

____

____

Frequency (if PRN please list parameters) ____

Special Instructions or Observations to be reported _______________________________________

Start Date_______________________ Stop Date___________________

_______________________________ _____________________________________

Physician's Signature Date Physician's Address

_____________________________________ _____________________________________

Physician's Printed Name Physician's Phone Number

I hereby request and give my permission to the Program Nurse or trained staff delegated by Program Nurse to administer the above treatment as ordered by physician. I agree to be responsible for supplying the necessary supplies for the treatment and to notify the Program Nurse of any changes in treatment.

_____________________________________ _____________________________________

Parent's Signature Date

____

Parent's Printed Name

BL 10/20