MEDICAL PROCEDURE
(this form optional fill out if it applies to your child)

Student's Name _____ Date of Birth _____

1. Physical condition for which the standardized procedure is to be performed:

   _____

2. Name of Standardize procedure:

   _____

3. Precautions, possible untoward reactions, and interventions:

   _____

4. The procedure is to be continued as above until: _____
   Date

Physician's Signature _____ Date _____

Physician's Address _____

Physician's Phone _____ Fax _____

I hereby request that the treatment specified above be performed to the above named child.

Parent/Guardian Signature _____ Date _____

MEDICATION REGULATIONS EXPLAINED IN THE PARENT HANDBOOK

Student's Name _____ Date _____

Name of Medication	Dosage	Time

Above medication(s) are prescribed for _____
and may be administered by the school personnel at the indicated times.

Physician's Signature _____ Date _____

Physician's Address _____

Physician's Phone _____ Fax _____

I hereby request and authorize school personnel to administer my child's medication.

Parent/Guardian Signature _____ Date _____