AUTHORIZATION FOR SPECIALIZED HEALTH CARE PROCEDURE
Pitt County Schools School Health Program

Return completed form to:_____RN, School Health Case Manager

_____ School

Student _____ DOB _____

Address _____ Phone _____

1. Health condition for which the specialized health procedure is needed:

   _____

2. Procedure or health service to be performed:

   _____

3. Precautions, possible reactions/side effects, and interventions:

   _____

4. Time(s) and/or indications for procedure or health service:

   _____

5. Procedure and/or health service to be continued until:

   _____

Date Comments

_____ _____
Medical Provider's Signature Date

_____ _____
Address Phone

TO BE COMPLETED BY PARENT

I hereby give permission for the above described procedure/health service to be performed for and/or by my student, _____, during school hours. I hereby release Pitt County Schools and their agents and employees from any and all liability that may result from this procedure.

_____ _____ _____
Parent/Guardian Signature Phone Date