

**FULTON COUNTY SCHOOLS
STUDENT HEALTH SERVICES FOR EXCEPTIONAL CHILDREN
SCHOOL HEALTH PROCEDURES**

STUDENT'S NAME: _____ DOB: ___/___/___

ADDRESS: _____

HOME PHONE: () _____ WORK/CELL PHONE: () _____

SCHOOL: _____ SCHOOL YEAR: _____

TO BE COMPLETED AND SIGNED BY PHYSICIAN. Please be specific.

1. Diagnosis or physical condition for which medication or procedure is to be performed:

2. Detailed description of needed medical procedure(s) including time:

3. Medications needed, dosage, and method of administration including time:

4. Allergies _____ History of Seizures ____ yes _ ____ no

5. Miscellaneous (Other pertinent medical history): _____

Physician's Name (please print): _____ Phone: () _____

Address: _____

PHYSICIAN'S SIGNATURE: _____ **Date:** _____

AS THE PARENT OF THE ABOVE NAMED CHILD, I AGREE TO THE ABOVE PROCEDURES. I WILL NOTIFY SCHOOL PERSONNEL IMMEDIATELY IF THERE IS A CHANGE IN THESE ORDERS. I UNDERSTAND I AM RESPONSIBLE FOR PROVIDING THE SCHOOL WITH WRITTEN DIRECTIONS FROM THE PHYSICIAN BEFORE THE SCHOOL WILL MAKE ANY CHANGES IN PROCEDURES OR MEDICATION. I AUTHORIZE STUDENT HEALTH SERVICES TO DISCUSS ORDERS WITH THE PRESCRIBING HEALTH CARE PROVIDER. I RELEASE THE SCHOOL BOARD, THE SCHOOL, AND ANY SCHOOL EMPLOYEE FROM ANY LIABILITY FOR PERFORMING THESE PROCEDURES OR ADMINISTERING ORDERED MEDICATIONS.

PARENT/GUARDIAN SIGNATURE: _____ **Date:** _____