TCESC PRESCHOOL PROGRAM
PHYSICIAN'S ORDER FOR SPECIALIZED HEALTH CARE PROCEDURE

Student's Name:_____________________________________ Birth Date:___________

Address:______________________________________ School District:____________

Phone: (Home)_____________________ Phone: (Work or Cell)__________________

Procedure:____

PHYSICIAN'S USE ONLY

______ I have reviewed the Health Care Plan and approve of it as written.

_______ I have reviewed the Health Care Plan and approve of it with the attached amendments.

_______ I do not approve of the Health Care Plan. A substitute plan is attached.

Other recommendations:____

Duration of the Procedure (Date):_______________

Physician's Signature:________________________________ Date:______________

Address:____ Phone:_______________

PARENT AUTHORIZATION FOR SPECIALIZED HEALTH CARE

We (I), the undersigned, who are the parents/guardians of the above named student, request that thehealth care service (s) listed above be administered to our child. It is our understanding that in performing this service the designated person(s) will be using a standardized procedure which has been approved by our physician.

I will notify the school immediately if the health status of __________________________ changes, if we change physicians, or there is a change or cancellation of the procedure.

Signature of Parent or Guardian:______________________________ Date:___________________

Written and Submitted by:___________________________________ Date:___________________
(Name)

Administrator:____ Date:___________________
(Name)

Date of next Review and Revision of Health Care Plan:_____________________________________
Health Care Plan should be revised according to child's specific needs.

Trumbull County Educational Service Center
6000 Youngstown Warren Rd. Niles, Ohio 44446
Phone: 330 505-2800 Fax: 330 505 2814