Hilliard City Schools

Request for Specialized Health Services

Student:____ D.O.B. ______________ Date:____________

Health Care Provider's Section

Diagnosis and brief history: ____

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Requested Procedure: ____

_____ I have reviewed and approved the attached procedural guideline as written.

_____ I have reviewed and approved the attached procedural guideline with the attached modification.

_____ I do not approve of the school's guideline and therefore have attached an alternative guideline.

Other recommendations (i.e. time, schedule and duration of treatment, special precautions, and possible complications: ____

____

Procedure to be discontinued or evaluated on this date: ____

Provider's Signature:______________________________________ Phone:_________________________

NPI#_________________________________ Approved Ohio ORP Provider: Yes/No

Provider's Address/Office Stamp: ____

Parent/Guardian Section

We (I), the undersigned parent/guardian of the above named student, request that the specialized health care service outlined above and authorized by my child's health care provider be provided for our child. We (I) authorized the school to appoint a qualified designated person(s) to perform the service as directed. It is our (my) understanding that in performing this service, the designee will be using the procedure as approved above. I (we) agree to notify school personnel immediately if there is any change in either the treatment regimen or authorizing health care provider. We (I) understand that the above service should be scheduled before or after school hours whenever possible.

Parent/Guardian Signature: _____________________________________ Date:____________________

Home phone: __________________ Work: ___________________ Cell:___________________________

School Nurse's Signature: ____________________________________ Date:________________________

CC: School, Parent, Provider