CHULA VISTA ELEMENTARY SCHOOL DISTRICT
84 East "J" Street ● Chula Vista, CA 91910 ● (619) 425-9600

Physician Authorization for Specialized Physical Health Care

Student's Name: _____ Birthdate: _____

Address: _____ City: _____ Zip Code: _____

I, the undersigned, as the physician for the above-named student, do recommend and approve the following procedure(s) to be provided or performed during the school day so that the student can attend school or benefit from his or her educational program.

1. Name of standardized procedure: _____
2. The physical condition(s) of the student is/are: _____
   _____
3. The procedure(s) is/are to be provided according to the following time schedule: _____
   _____
4. Please check one item:
   - ☐ I have reviewed and approved the attached procedure as written.
   - ☐ I have reviewed and approved the attached procedure with my modifications noted.
   - ☐ I have attached my recommendations or orders for the procedure.
5. Please list any signs/symptoms that may indicate an emergency situation and list any emergency procedures: _____
   _____
6. List any concerns about transporting the student on the school bus: _____
   _____

_____ _____
Signature of physician Printed name of physician

_____ _____
Address License #

_____ _____
Date Phone Number

Rev. 09/11