1120 Dahlonega Highway • Cumming, Georgia 30040 • Telephone 770.887.2461 • Fax 770.781.6632

PARENT'S REQUEST AND AUTHORIZATION
FOR SPECIALIZED HEALTH CARE

DATE:__________________

SCHOOL:_____________________ PRINCIPAL:_________________________

NAME OF STUDENT:_____________________________DATE OF BIRTH:_______________

We, the undersigned, who are the parents/guardians of _________________________ request that the following specialized health care be administered to our child.

PROCEDURE:____

We understand that the procedure will be done by designated school personnel under direct or indirect supervision, after appropriate training. It is also understood that Forsyth County school personnel are released from responsibility for any complications resulting from administration of this procedure.

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

We understand that whenever possible, the specialized health care procedure should be provided by the family before or after school hours.

___________________________________ _____________________________
Signature of Parent/Guardian *Date*