BURLINGTON COMMUNITY SCHOOL DISTRICT
STUDENT HEALTH SERVICES
SPECIALIZED PROCEDURES AUTHORIZATION FORM

NO. 507.8E1

Name of Student: ______________________________ Birth Date: _________________________

Address: ____

1. Physical condition for which the standardized procedure is to be performed (related diagnosis and ICD 10 code): ____

2. Name of standardized procedure: ____

____

3. Precautions, possible untoward reactions, and interventions: ______________

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4. Time schedule and/or indication for the procedure: _________________________

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____

The procedure is to be continued as above until: __________________________

____ ______________________________
(Date)

____ ______________________________
Physician/Therapist/Registered Nurse Signature (Date)

____ ______________________________
Address Telephone

I hereby request that the treatment specified above be performed to the above-named child.

____ ______________________________
Signature of Parent/Guardian (Date)

FOR SCHOOL USE ONLY:

THE ABOVE PROCEDURE WILL BE PERFORMED/ADMINISTERED BY:

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Revised: 07/13/15 Reviewed: ~~07/18/16~~ 11/15/21