MOLALLA RIVER

AUTHORIZATION FOR SPECIALIZED CARE

Student: DOB:

School:

As the parent or guardian of the above referenced student, I request that my child receive the following specialized health services:

I understand that:

- This authorization is valid for one year from the date of my signature below.
- Qualified, designated persons will be performing the above-mentioned health care service(s) and the designated persons will be trained and supervised by a registered nurse as authorized by OAR 851-047-0000.
- I will notify the school immediately if the health status changes, if there is a change of physicians, changes to physician's orders, and/or change or cancellation of health care.
- I am responsible for bringing to school all necessary supplies, medications and orders to school.

Parents Signature Date