REQUEST FOR AUTHORIZED PERSONNEL TO PERFORM A PROCEDURE AT SCHOOL

Peoria Heights School District #325

To be completed by the physician or authorized prescriber

When it is necessary for a student to have a physician-prescribed procedure performed at school, the following information **must be provided:**

Student Name: _____ Grad Year: _____

Diagnosis/Reason for Medical Procedure: _____

Corresponding ICD-9 Code: _____

Name of Procedure: _____

Time of Procedure: _____

Special Instructions:

Date: _____ Physician Signature: _____

Physician's Name & Address: _____

Phone Number/Fax Number: _____

To be completed by parent/guardian

I give permission for (name of child) _____ to receive the above procedure at school.

Date: _____ Signature: _____ Relationship: _____

I hereby confirm my primary responsibility to perform the above stated procedure to my child. However, in the event that I am unable to do so, I hereby authorize Pleasant Hill School and its employees and agents, in my behalf and stead, to perform the procedure or attempt to perform the procedure to my child. I further acknowledge and agree that, when the lawfully prescribed procedure is so administered or attempted to be administered I waive any claims I might have against the School District, its employees and agents arising out of the performance of the procedure. In addition, I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the procedure or attempts at performing the procedure.