CHINO VALLEY UNIFIED SCHOOL DISTRICT
5130 RIVERSIDE DRIVE, CHINO, CA 91710-4130
(909) 627-3584 FAX: (909) 548-6090

Physician's Authorization For Specialized Physical Health Care Services (SPHCS)

(NAME OF STUDENT)_____(DATE OF BIRTH)_____

I, the undersigned, as the physician for the above-named student, do recommend and approve the following procedure(s) to be provided to this student during school hours:

1. Name and description of procedure(s): _____

_____

_____

_____

2. The physical condition of this pupil is: _____

_____

3. The procedure(s) is (are) to be provided according to the following time schedule or PRN (as necessary): _____

_____

and should be continued until (maximum one school year_____

4. (Please check one item and sign the attached procedure)

☐ a. I have reviewed and approved the attached procedure as written.
☐ b. I have reviewed and approved the attached procedure with my modifications, which I have noted.
☐ c. I have attached my recommendations or orders for the procedure.

5. Signs or symptoms that may indicate an emergency situation are: _____

Emergency procedure(s)

_____

_____

6. Concerns regarding transporting the student on the school bus are: _____

_____

7. I understand that the procedure(s): a. must be one(s) that can be learned in a reasonable amount of time, b. should not require the presence of a physician, medical judgment based on extensive medical training, or an undue amount of time to be provided or performed, c. must be provided or performed during the school day so that the student can attend school or benefit from his/her educational program, and d. must be ordered by a licensed California physician and surgeon.

8. The medical justification for providing the procedure(s) during school hours is: _____

_____

_____ ( ) _____

(signature of physician) (printed name) (phone)

_____

(street address) (city) (state) (zip code)