Health Services • 1120 Dahlonega Highway • Cumming, Georgia 30040 • 770-887-2461

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.

_____

Parent/Guardian Name (Please Print)

_____

Parent/Guardian Signature

_____

Date