SPECIAL EDUCATION ASSOCIATION OF PEORIA COUNTY

4812 W. Pfeiffer Rd., Bartonville, IL 61607
PH: 309-697-0880 FAX: 309-697-0884

Physician Authorization To Perform A Procedure At School

To be completed by physician or authorized prescriber

Student:	DOB:	Serving Dist:	DOR:	Grade:	SIS:

Name/Time of Procedure:
Special Instructions:

Effective Dates (limited to one school year): From_____ / To_____
Diagnosis/Reason for Medical Procedure:

Physician's Signature:	Date:
Physician's Name & Address:	
Phone:	Fax:

PARENT/GUARDIAN AUTHORIZATION:

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 SEAPCO 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 of attempts at performing the procedure.

Parent/Guardian (Printed Name) **Parent/Guardian** (Signature) Date