Physician's Permission to Administer Care

I ______________________________ verify the following for ______________________:
Physician patient

The above mentioned individual requires _________________________________ for the
type of care

purpose of____
medical condition

This procedure:

Does the manufacturer of this product state that the product can be administered by someone who is not a licensed medical professional? _________ yes _________ no

______ may be administered by a non-medical personnel who is trained in the procedure by the parent or other qualified individual.

______ may not be administered by non-medical personnel.

Please attach written protocol for the administration of the above procedure.

_____________________________________ ___________________
Physician Signature Date

I _____________________________ give permission to share the above information with
participant / guardian

appropriate District staff, for the purpose of provision of care for myself/my child.

_____________________________________ ___________________
Signature (self/guardian) Date