**Personal Care Services** are a range of human assistance services provided to persons with disabilities and chronic conditions which enable them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of the hands-on assistance or cueing so that the person performs the task by him/herself.

**Personal Care Services** may include, but are not limited to, assisting with the following:

* Eating/feeding
* Respiratory assistance
* Toileting
* Grooming
* Dressing
* Transferring
* Ambulation
* Personal hygiene
* Mobility/Positioning
* Meal preparation
* Skin care
* Bathing
* Maintain continence
* Assistance with self-administered medications
* Redirection and intervention for behavior
* Health related functions through hands-on assistance, supervision, and cueing
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student Information**: (Note:For scanning purposes, please use only black or blue ink when completing this form.)

Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IEP Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attending District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attending School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Aide: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Classroom Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization:** Personal care services require an authorization by a licensed practitioner, including Registered Nurses, Occupational Therapists, Physical Therapists, Master of Social Work, and Speech Language Pathologists, operating within the scope of their practice.

**Licensed Practitioner Authorization:**

I certify that the above named student requires daily personal care services, as checked above, due to their disability or medical condition:

Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse Name/Designation

**This authorization must be updated annually and kept in the student’s records for seven years.**