## *FORT WORTH INDEPENDENT SCHOOL DISTRICT*
### *Health Services Department*

## Specialized Health Care Procedure Authorization Form
### *Physician's Request for School Health Services*

The Fort Worth Independent School District Health Services Department Personnel or other designated employees will provide specialized health care procedures when they are required for students to remain in school. The school nurse will coordinate all procedures in the building(s). The Specialized Health Care Procedure Authorization Form must be completed each school year for all specialized health care procedures provided at school. It must include the physician/licensed prescriber's signature and parent/guardians signature.

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**School Name:** _____ **School Year** _____

**Name of Student:** _____ **DOB** _____

Based on my evaluation as a physician/licensed prescriber, the above named student requires the following health care service(s) in order to be educated at school:

Name of Procedure(s) (Please include name and dosage of medication if appropriate):

_____

_____

_____

Effective from: _____ through: _____

Physical condition for which procedure is to be performed: _____

_____

Times scheduled and indication for procedure: _____

_____

Physician's Directions: _____

_____

Precautions, possible reactions: _____

_____

Circumstances in which the physician should be contacted: _____

_____

The following person(s) as designated by the principal, may be trained by the school nurse to perform the above listed procedures: Health Assistant, Teacher, Aide, Secretary/Clerk, and/or other.

Physician's Name (Print) _____ Signature: _____

Date: _____ Address: _____

Telephone: _____ Fax: _____

## *FORT WORTH INDEPENDENT SCHOOL DISTRICT*
### *Health Services Department*

## Parent's Request for School Health Services

I, the undersigned, parent/guardian of _____

D.O.B. _____ request that the following specialized health care(s) be be administered to my child during school hours:

_____
Name of Procedure(s)

I understand that I am responsible for providing all medications and equipment needed to perform the service.

I release those persons designated by my physician/licensed prescriber to perform the service from all liability.

I understand that whenever possible the specialized health care service should be provided before or after school hours.

I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed procedure(s) or medical condition(s) being treated.

I will notify the school immediately if the health status of my child changes, if I change physicians/licensed prescribers, or if the procedure is changed or cancelled.

_____
Signature of Parent/Guardian

Date: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

**Note: This request must be resubmitted every school year. Medical equipment and supplies provided by the family for Specialized Health Care Procedures will be sent home for thorough cleaning and/or to be replaced as needed.**