

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.

School Name: Daggett Montessori **School Year** 2024-2025

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 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.

DISTRITO ESCOLAR INDEPENDIENTE DE FORT WORTH
Departamento de Servicios de Salud

Formulario de Autorización para Procedimientos de Cuidado Médico Especializado
Solicitud del Médico para Servicios de Salud en la Escuela

El personal del Departamento de Servicios de Salud del Distrito Escolar Independiente de Fort Worth, u otros empleados designados, proporcionará procedimientos de cuidado médico especializado cuando sean requeridos para que los estudiantes permanezcan en la escuela. La enfermera de la escuela coordinará todos los procedimientos en el edificio(s). El formulario de autorización de procedimientos de cuidado médico especializado debe ser llenado cada año escolar para todos los procedimientos de cuidado médico especializado proporcionado en la escuela. Debe incluir la firma del médico/persona autorizada para recetar y la firma del padre/guardián/

School Name: Daggett Montessori **School Year** 2024-2025

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): _____

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: _____

DISTRITO ESCOLAR INDEPENDIENTE DE FORT WORTH
Departamento de Servicios de Salud

Solicitud de los padres para servicios de salud en la escuela

Yo, abajo firmantes, padre/guardián de _____

Fecha de nacimiento _____ solicito que el siguiente servicio(s) de cuidado médico especializado sea administrado a mi hijo/a durante las horas de escuela:

Nombre del procedimiento(s)

Yo comprendo que soy responsable de proporcionar todos los medicamentos y equipo médico.

Yo libero de toda responsabilidad a aquellas personas designadas por nuestro médico/persona autorizada para realizar el servicio.

Yo comprendo que cuando sea posible el servicio de cuidado médico especializado deberá ser proporcionado antes o después de las horas de escuela.

Yo doy permiso para que la enfermera consulte con el médico/persona autorizada del estudiante antes mencionado sobre cualquier pregunta que surja respecto al procedimiento(s) indicado o condición(es) médica que está siendo tratada.

Yo notificare a la escuela inmediatamente si el estado de salud de mi hijo/a cambia, si cambiamos de doctores/personas autorizadas, o si se cambia o cancela el procedimiento.

Firma del padre/guardián

Fecha: _____

Teléfono de la casa: _____

Teléfono celular: _____

Teléfono del trabajo: _____

Nota: Esta solicitud se debe volver a presentar cada año escolar. El equipo y materiales médicos proporcionados por la familia para los procedimientos de cuidado médico especializado serán enviados a casa para ser limpiados a fondo y/o reemplazados cuando sea necesario.