

*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/guardian signature.

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): _____

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
Health Care Services Provided At School
Parent's Request for School Health Services*

I (we) the undersigned, parents/guardians of _____

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

Name of Procedure(s)

I (we) release those persons designated by our physician/licensed prescriber to perform the service from all liability.

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

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

Signature of Parents/Guardians

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.