Bandera Independent School District

Authorization for Administration of Specialized Physical Health Care Services

Name of Student: _____ Birthdate: _____

Address: _____City: _____Zip: _____

Physical condition for which procedure is to be performed: _____

Name of treatment or procedure: _____

Check one:

☐ **I have reviewed and approved the attached standardized procedure as written.**

☐ **I have reviewed and approved the attached standardized procedure with my modifications noted.**

☐ **I have attached my recommendations for standardized procedures.**

Precautions, possible untoward reactions and recommended intervention(s):

_____

Time schedule and/or indication for the procedure: _____

The above treatment cannot be scheduled for other than during school hours.

The treatment to be continued until _____ (date).

Date of Physician's Authorization for Treatment: _____(date).

Physician's Signature: _____ Phone: (_____)_____-_____

Address: _____ City: _____ Zip: _____

Parent's Signature: _____ Date: _____

_____

For School Use Only

Principal's Signature: _____Date: _____

School Nurse's Signature: _____Date: _____

(BISD, 2010)

_____

Student Name Date of Birth

1. I request that the following specialized physical health care services be administered to my child.

   (indicate name of procedure) _____
   _____

   _____

2. This procedure is necessary for my child to attend school and cannot be provided before or after school hours.

3. I request that the treatment be administered in accordance with the Physician's Authorization for Specialized Health Care form. I will notify the school if the health status of my child changes, we change physicians, or the procedure is changed or cancelled.

4. I agree to bring the necessary equipment and supplies – properly labeled- with directions for use in school.

5. The school is authorized to secure emergency medical services for my child whenever the need for such services is deemed necessary by the principal, the school nurse, teacher or other school personnel.

6. In consideration of this authorization made at my request, I agree to indemnify and hold harmless the Board of Trustees and school personnel administering the treatment from any claim or liability for injury, or damaged caused or claimed as a results of the requested treatment.

7. I hearby give permission for exchange of confidential information contained in the record of my child between _____ (physician) and _____ (school nurse).

_____ _____

Physician's Name School Nurse

_____ _____

Physician's Signature School Nurse's Signature

_____

Parent/Guardian Signature

_____ _____

Date Parent's Address

_____ _____

Home Telephone Work Telephone

(June 2010)