FORT WORTH INDEPENDENT SCHOOL DISTRICT

Health Services Department

Specialized Health Care Procedure Authorization Form

The Fort Worth Independent School District Health Services Department requires that unlicensed personnel perform specialized health care procedures when they are required for students to remain in school. The school nurse will coordinate the training and supervision in the building(s). The Specialized Health Care Procedure Authorization Form must be completed each school year for a student to receive specialized health care provided by unlicensed personnel. It must include the physician/licensed prescriber's signature and parent/guardian's signature.

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 procedure is medication)

_____

_____

Effective from: _____ through: _____

Physical condition for which the procedure is to be performed: _____

Activities scheduled and indication for procedure: _____

_____

Physician's Directions: _____

_____

_____

Circumstances in which the physician should be notified: _____

_____

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

Physician's Name: (Print) _____ Signature _____

Date: _____ Address: _____

Telephone: _____ Fax: _____

FORT WOR[illegible]

Health Se[illegible]s Department

Parent's Req[illegible] 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.

[illegible]

I understand that I am responsible for providing all medications and equi[illegible] needed to perform the ser[illegible]

I release those persons designated by [illegible] physician/licensed prescriber to perform the serv[illegible] liability.

I understand that [illegible] possible the specialized health care service sh[illegible] be provided before or after school hours.

I give per[illegible] any questions that arise with regard to [illegible]

I will notify the school immediately if the health status of my child cha[illegible], if I change physicians/licensed prescrib[illegible] or if the procedure is [illegible]

____
Signature of Parent/Guardian

Date: ______________________

Home Phone: ______________________

Wo[illegible]hone: ______________________

Note: This [illegible]

be replaced as needed...