HEALTH SERVICES
Prosper Independent School District

Physician/Parent Authorization for Special Health Care

*This form to be renewed annually and as changes occur.

Student: _____ DOB: ____/____/____ Grade: _____ Date of Plan: ___/____/____

TO BE COMPLETED BY THE PHYSICIAN:

This student has been referred for consideration of, or continuation of, Health Services. Nursing Services are provided to students with disabilities who must have these services in order to benefit from instruction. Please respond to the following inquiries based on your examination and knowledge of the student and sign in the space provided.

Diagnosis or description of disability/special health need:_____

_____

*Please attach a copy of any medical and developmental history that may be pertinent to the therapy program.

List the standardized procedure(s) to be performed: _____

Special instructions regarding this procedure (Please attach facility protocol, if applicable) _____

_____

_____

Is this a procedure that can be performed totally outside the school day? ☐ Yes ☐ No

Times to be performed during the school day (*may vary up to ½ hour to accommodate school schedule): _____

_____

Precautions, possible untoward reactions, and interventions:_____

_____

The procedure is to be continued as above until: _____

The parent/guardian is responsible to provide all equipment necessary for the prescribed health care procedure at school. What equipment should the parent provide in order for this procedure to be performed?_____

_____

SELF-CARE /ADMINISTRATION:

Can this procedure be safely performed by the student in the school setting? ..... Yes No

This student has been provided instruction/supervision and is capable of performing the above procedure..... Yes No

Does this student need the supervision of a designated adult? ..... Yes No

Does this student have physician permission to provide self-care/administration of this procedure?..... Yes No

Physician Name: _____ **Signature**: _____ Date:_____

Clinic/facility: _____ Phone: (_____)_____

TO BE COMPLETED BY THE PARENT/GUARDIAN ----------

I, the undersigned, the parent/guardian of _____ request that the above named specialized physical health care service to be administered to my child. I understand that it is my responsibility to provide the necessary equipment and supplies in order for the above health care service to be performed at school by district personnel. I understand that the school administration will appoint a qualified designated person to perform the above mentioned health care service. It is my understanding that in performance of the service, the designated person(s) will be using a standardized procedure that has been approved by the physician. I will notify the school immediately if the health status of my child changes, I change physicians, or the procedure is canceled or changed in any way. I understand that whenever possible the specialized health care procedure should be scheduled outside of school hours. I also give my consent to release medical/health records and permission to appropriate school staff to contact the physician/health care provider for additional information if needed.

Parent's Signature: _____ **Date**:_____

FOR SELF-ADMINISTRATION ONLY

I, the parent/guardian of _____ request that the above mentioned healthcare procedure be self-administered by my child. It is my understanding that in performance of the procedure, my child will be using a standardized technique and process that has been approved by the physician. I understand that PISD reserves the right to require that this procedure be performed in the clinic if in the school nurses judgment, the student cannot or will not perform the procedure in a safe manner according to the physician's instructions.

Parent's Signature: _____ Date: _____