Lamar Consolidated Independent School District
HEALTH SERVICES

SPECIALIZED PROCEDURES FOR HEALTHCARE
PARENT AND PHYSICIAN AUTHORIZATION

Student Name: ____ **Student Date of Birth:** _____________

Health Condition/History Requiring Treatment:____

Name of Specialized Healthcare Procedure: ____(One form PER Procedure)

MUST BE COMPLETED BY PHYSICIAN:

The above-named student is under my care and will require a specialized healthcare procedure **during school hours** as indicated below:

Frequency of Treatment: (please check all that apply and specify as needed)

____ Treatment should be administered at :__________ (Specify time of day by hour and AM/PM)

____ Treatment should be administered according to the following indicators:

____

____

Duration of Treatment:

This procedure should be continued until:(Please check one)

____ End of School Year to include Summer School

____ Date: __________ Parent and Physician-Please note-This form must be completed every school year

Precautions/Adverse Reactions associated with Treatment: (Please specify)

____

____

____

Instructions for Performing the Procedure:

____

____

____

PLEASE NOTE: CLARIFICATION AND/OR REVIEW OF THE PROCEDURE MAY BE NECESSARY FOR THE SCHOOL NURSE AND/OR SCHOOL PERSONNEL TO PROPERLY PERFORM THE PROCEDURE. PLEASE PROVIDE THE NAME OF A QUALIFIED CONTACT PERSON FOR THE SCHOOL NURSE/PERSONNEL TO CONTACT FOR CLARIFICATION:

Qualified Contact Name:____________________________________ **Phone Number:** ______________________

PHYSICIAN NAME (Print): ____________________________________ **Phone:** ______________________________

PHYSICIAN SIGNATURE: ______________________________________ **Date:** _______________

MUST BE COMPLETED BY PARENT:

As the undersigned parent/guardian of the student named above, I understand the following:

1. **I request the Specialized Healthcare Procedure indicated above will, whenever possible, be provided at home.**
2. **I will notify the School Nurse in writing if:**
   - **the health status of the above named student changes**
   - **the student's physician named above ceases to care for the student AND/OR**
   - **the requested procedure is changed in any way or is discontinued.**
3. **I authorize the exchange of information, which may be confidential, between the School Nurse and the office of the physician named above.**
4. **I understand that it is my responsibility to provide ALL supplies and equipment needed for the above named procedure.**

PARENT NAME (Print): ____ **Home Phone:** __________________

Cell Phone: ______________ **Work Phone:** _________________ **Email:** ____________________________________

PARENT SIGNATURE: ____ **DATE:** _________