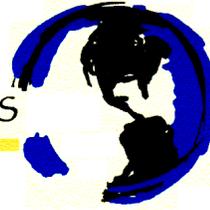


TULSA PUBLIC SCHOOLS

HEALTH SERVICES



REQUEST FOR TREATMENT DURING SCHOOL HOURS

Name of Child _____ Date of Birth _____

Address _____

Etiology _____

Date of Onset _____

Prognosis _____

Procedure to be Performed _____

Frequency _____

Precautions, possible untoward reactions, interventions _____

Any other pertinent history of physical findings that may affect this procedure _____

Signature of Parent/Legal Guardian
Or Person Responsible for Student's
Care

Date

Physician's Signature (if required)

Date

Telephone #

Physician's Telephone #

NOTE: Physician's request must be renewed at the beginning of each school year. Any change of treatment must be requested in writing.

COMPLETE NEW FORM FOR EACH PROCEDURE