Home of the New Braunfels Unicorns!

NEW BRAUNFELS INDEPENDENT SCHOOL DISTRICT
1000 N. Walnut, New Braunfels, Texas 78130
Phone: 830.643.5700 | Metro: 830.606.1423 | Fax: 830.643.5701

Physician and Parent Authorization for Special Health Care

Name of student_____ **Birth date**_____

To Be Completed By The Physician:

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

2. Name of standardized procedure: _____

3. Precautions, possible reactions, and interventions: _____

4. Time schedule and/or indication for the procedure: _____

5. Procedure to be continued as above until: _____

6. Procedure to be performed by: _____

_____ _____
Physician's Signature Date

_____ _____
Physician's Address Phone

To Be Completed By Parent or Guardian

We will notify the school immediately if the health status of my child changes, we change physicians, or the procedure is changed or cancelled. We understand that, whenever possible, the specialized physical health care service should be provided before or after school hours.

I request this procedure be performed on my child according to the above instructions. I authorize the physician to release medical information regarding my child to school health or administrative personnel:

_____ _____
Parent or Guardian Signature Date

_____
Address

_____ _____ _____
Home Phone Work Phone

Home of the New Braunfels Unicorns!

NEW BRAUNFELS INDEPENDENT SCHOOL DISTRICT
430 W. Mill, New Braunfels, Texas 78130
Phone: 830.643.5700 | Metro: 830.606.1423 | Fax: 830.643.5701

Physician and Parent (Spanish) Authorization for Special Health Care

Name of student_____ **Birth date**_____

To Be Completed By The Physician:

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

2. Name of standardized procedure: _____

3. Precautions, possible reactions, and interventions: _____

4. Time schedule and/or indication for the procedure: _____

5.Procedure to be continued as above until: _____

6. Procedure to be performed by: _____

Physician's Signature _____ Date _____

Physician's Address _____ Phone _____

Ser completado por padre or tutor:

Nosotros le comunicaremos a la escuela imediatamente si el estado de salud de mi hijo/a cambia, cambiamos de médico, o el procedimiento ha cambiado o se ha cancelado. Nosotros comprendemos que, cuando sea posible, el servicio especializado del bien estar de la salud física debe ser suministrado antes o despues de las horas escolares.

Solicitamos servicio especializado de la salud física para ser administrado a nuestro hijo/a:

Firma de el/los padre tutor _____ Fecha _____

Dirección _____

Teléfono Hogar _____ Teléfono Trabajo _____ Teléfono Cellular _____