FABENS INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES
PO BOX 697 FABENS, TX 79838

MEDICAL INSTRUCTIONS FOR SCHOOL

Student Name: _____ Date: _____
School: _____ Grade: _____ ID#:_____DOB: _____
School Phone: _____ Fax: _____
School Nurse Name: _____

Restrictions/Modifications:

Medical Diagnosis: _____

This student should be restricted from:
☐ Physical Education ☐ Other Activity: _____
_____
From (date): _____ until (date):_____

Classroom Modifications: _____
_____
Diet Restrictions/Modifications: _____
_____

Medication(s)

This student should take the following medication(s) while at school:

	Medication Name	Strength	Dose	Route	Time (at school)
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

Duration: ☐ Entire School Year ☐ Other _____

Physician's Signature: _____
Address: _____ Date: _____
Phone Number: _____ Fax: _____

Parent(s)/Guardian Signature/Firma del Padre/Tutor: _____
Phone/Cell Number/Numero de Tel. /Celular: _____Date/Fecha: _____

(School Health Office Use Only)

Date Received: _____ Date Reviewed by School Nurse: _____
Nurse Signature: _____
Instructions sent to the following school personnel: _____
_____ Date: _____