CELINA INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES

Specialized Healthcare Conditions and Procedures Physician/Parent Authorization Form

Student: _____ DOB: ___/___/___ School/Grade/Homeroom:_____

TO BE COMPLETED BY THE PHYSICIAN

This student has been referred for consideration of, or continuation of, school health services. These are provided to students with disabilities who must have these services 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.

1. Diagnosis or description of disability/particular health need (Please attach a copy of any medical and developmental history pertinent to the therapy program):

   _____

   _____

2. List the standardized procedure(s) to be performed:

   _____

   _____

3. Special instructions regarding this procedure (Please attach facility protocol, if applicable):

   _____

   _____

4. Is this a procedure that can be completed outside the school day? ☐ Yes ☐ No

5. Times to be performed during the school day (*may vary up to 1/2 hour to accommodate the school schedule):

   _____

6. Please list any special precautions, possible unexpected outcomes, and preferred interventions:

   _____

   _____

   _____

7. The parent/guardian is responsible for providing all equipment necessary for the prescribed health care procedure at school. What equipment should the parent provide for this procedure?

   _____

   _____

PHYSICIAN CONT.
FOR SELF-CARE/ADMINISTRATION STUDENTS ONLY

1. Can this procedure be safely performed by the student in the school setting?
   - ☐ YES
   - ☐ NO
2. This student has been provided instruction/supervision and can perform the above procedure.
   - ☐ YES
   - ☐ NO
3. Does this student need the supervision of a designated adult?
   - ☐ YES
   - ☐ NO
4. 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 OR GUARDIAN

I, the parent/guardian of _____, request that specialized health care services be administered to my child. I understand that it is my responsibility to provide the necessary equipment and supplies for the above health care service to be performed at school by district personnel. I know that the school administration will appoint a qualified designated person to perform the procedure(s) ordered above. It is my understanding that in the performance of the service, the designated person(s) will be using a standardized procedure that the physician has approved. I will notify the school immediately if my child's health status changes, I change physicians, or the procedure is canceled or changed in any way. The specialized health care procedure should be scheduled outside of school hours whenever possible. I also 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:_____

PARENTAL CONSENT FOR SELF-ADMINISTERED PROCEDURES

I, the parent/guardian of _____, request that my child self-administer the above-mentioned healthcare procedures. While performing the procedure, my child will use a standardized technique and process the physician has approved. I understand that CISD reserves the right to require this procedure to be performed in the clinic if, in the school nurse's judgment, the student cannot or will not safely perform the procedure according to the physician's instructions.

Parent's Signature: _____ Date: _____