South San Antonio Independent School District

Department of Health Services

ORDER FOR SPECIALIZED HEALTH CARE PROCEDURES /and or TREATMENTS

The South San Antonio Independent School District requires the following for all students who require procedures/treatments during the school day.

A. **Written doctor's order**
B. **Written permission signed by the parent or legal guardian**
C. **Supplies and equipment necessary for procedure/treatment.**

STUDENT'S NAME_____DOB_____SCHOOL_____

CONDITION/DIAGNOSIS _____

_____

_____

NAME/DESCRIPTION OF PROCEDURE: _____

_____

START DATE _____STOP DATE _____

TIME(S) AND/OR INTERVALS PROCEDURE IS TO BE DONE _____

_____AMOUNT (if applicable): _____

SPECIAL INSTRUCTION (EQUIPMENT USED: TYPE, SIZE ETC.): _____

_____

PRECAUTIONS AND/OR POSSIBLE ADVERSE REACTIONS_____

_____

NOTIFY DOCTOR/PARENT IF: _____

_____

ADDITIONAL INSTRUCTIONS: (Continue on back if necessary) _____

_____

PRECAUTIONS NEEDED IF STUDENT IS TO RIDE SCHOOL BUS: _____

_____

_____

Authorization for this procedure is required annually.

DOCTOR'S NAME (please type or print) _____PHONE_____
DOCTOR'S SIGNATURE _____DATE _____

_____

I hereby give my permission for my child to receive the specialized procedure named above as prescribed by my child's doctor.
PARENT SIGNATURE _____DATE_____

HS-8/10