BISD Preparing Our Next Generation | Health Services Department

Physician Request for Special Procedures

Student's Name: _____ Birth date: _____ School: _____

Allergies: _____

Condition for which procedure is to be performed: _____

Procedure to be performed: _____

Frequency: _____

Remarks/Details: _____

_____

_____

_____
Physician Name/Telephone #

_____
Physician's Signature

_____ _____
Nurse Signature Date

This is permission to perform the special procedure to my child named above. I understand that I am giving consent for the school nurse to discuss any concerns regarding this procedure with the healthcare provider whose signature appears on this document in order to monitor the healthcare needs of my child

_____
Signature of Parent or Guardian

_____ _____
Telephone # Date