ALEDO INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES
1008 BAILEY RANCH ROAD
ALEDO, TEXAS 76008

Physician/Parent Authorization for Special Health Procedures

Student: _____ DOB: _____ Grade: _____ Date: _____

TO BE COMPLETED BY PHYSICIAN:

Diagnosis/description of special health need: _____
Procedure to be performed: _____
Times to be performed during the school day (*May vary up to ½ an hour to accommodate school schedule):
_____
Precautions/Possible Reactions:_____
Procedure is to be continued until: _____
What equipment should the parent provide in order for this procedure to be performed?
_____

SELF-CARE/ADMINISTRATION (IF APPLICABLE):

Can this procedure be safely performed by the student in the school setting? ☐ YES ☐ NO

Is this student capable of performing this procedure? ☐ YES ☐ NO

Does this student need the supervision of an adult for this procedure? ☐ YES ☐ NO

Does this student have physician authorization to provide self-care/administration of this procedure? ☐ YES ☐ NO

Physician Name: _____ **Signature:** _____ **Date:** _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I, the parent/guardian of _____, request that the above specialized physical health care procedure be provided to my child. I understand that it is my responsibility to provide the necessary equipment and supplies in order for the above health care procedure to be performed at school by authorized Aledo ISD staff (or my child, if the physician indicated self-care/administration above). It is my understanding that the above procedure will be completed according to the physician's orders. I will notify the school immediately if the health status of my child changes, or the procedure is canceled, or changed in any way. I understand that whenever possible the specialized health care procedure should be scheduled outside of school hours.

Parent Name: _____ **Signature:** _____ **Date:** _____