Specialized Healthcare Procedure at School

Revised 2026

This form is valid for the current school year: 20_____ - 20_____

Student Information

Student Name: _____ Date of Birth: _____ Student ID#: _____

Grade: _____ HR Teacher: _____ Diagnosis: _____

Physician Order

This section to be completed by Physician

Specialized Nursing Procedure to be Performed: _____

Frequency of procedure during school day:

- ☐ PRN (indication): _____
- ☐ Every _____ hours
- ☐ Specific times as listed: _____, _____, _____, _____

Length of time needed at school:

- ☐ Temporary/Short term from _____ to _____
- ☐ Daily (all school year)

Additional information regarding this procedure: _____

Authorization

Physician Authorization:

I authorize the administration of the above-named medications/treatments to this student during school hours.

Physician Signature: _____ Date: _____

Physician Name (printed): _____ Physician Phone: _____

Parent/Guardian Authorization:

My signature below indicates that I request GPISD staff or contracted outside agency staff to administer the medications/treatments specified above to my child, and I am giving permission for GPISD staff or contracted outside agency staff to contact the physician for additional information, if needed. *Mi firma a continuación indica que solicito al personal de GPISD o al personal externo contratado de la agencia que administre la medicación indicada para mi hijo(a), y le estoy dando permiso para el personal GPISD o contratada fuera del personal de la agencia en contacto con el médico para información adicional, si es necesario.*

- ☐ I have provided the school with the correct medication/dosage in its original container.
- ☐ I understand a new form is needed for all changes in medication, dose, amount of feeding, rate, etc.
- ☐ I understand all medication and supplies shall be brought to the school by a parent/guardian or responsible adult.
- ☐ Unless otherwise specified, this order is valid for the entire school year including summer session if applicable.
- ☐ Expired and discontinued medication/supplies not picked up by the last day of school will be destroyed.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (printed): _____ Phone: _____