PORT NECHES-GROVES I.S.D.

PHYSICIAN'S AUTHORIZATION FOR SPECIAL HEALTH CARE
SCHOOL YEAR ________

THIS FORM MUST BE COMPLETED ANNUALLY PRIOR TO THE FIRST DAY OF ENROLLMENT

Name of Student: ____________________________________ Birthdate: ___________________

Address: ____

1. ____P
hysical condition for which the standardized procedure is to be performed with written detailed procedure information:

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2. ____N
ame of standardized procedure: ____

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3. ____S
pecific recommendations: ____

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4. ____P
recautions, possible untoward reactions, and interventions:

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5. ____T
ime schedule and/or indication for procedure: ______________________________________

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6. ____T
he procedure is to be continued until:

____

Date: _______________________ Physician's Signature: __________________________________

Physician's Printed Signature: ____

Address: ____

Phone: _______________________ Fax: ____

I hereby request that the special healthcare above be performed to the above-named child.
Date: _______________________

Parent Signature: ____________________ School Nurse Signature: _______________________

Date filed in nurse's office: ________________________