Weimar Independent School District
HEALTH SERVICES DEPARTMENT

Specialized Health Care Procedure at School

In order for a specialized health care procedure to be administered at school, Part I (Physician section) and Part II (Parent section) of this form must be completed and returned to the school nurse. This form will need to be completed on an annual basis to ensure that the most current procedure/treatment prescribed is being administered at school.

Student's Name: Last	First	Middle	Date of Birth (MM/DD/YY)	Teacher/Grade

Name of Specialized Health Care Procedure:	Physical Condition Requiring Treatment:

PART I- To be completed by Physician:

The above-named patient is under my care and will require a specialized health care procedure/treatment during school hours as indicated below:

Specialized health care procedure/treatment to be administered according to one or both of the following methods:

☐ Time schedule, specify:

☐ Health need of the procedure/treatment at school based on the following health indicators:

☐ Both methods should be used to determine treatment, if checked.

Precautions and/or adverse reactions to look for during or following the procedure are as follows:

The procedure should be continued as ordered above until:

☐ End of school year

☐ Next physician visit (date of visit: _____)

☐ Other, explain: _____

Training or the review of a procedure may be necessary for a school nurse who has not had recent experience in administering or monitoring the performance of a specialized health care procedure. Please provide instructions or the names of contact persons qualified to review or train the school nurse or other school personnel who work with this student during the school day.

Instructions for performing the procedure:

Qualified Contact(s)- Name and Phone Number:

Physician's Name (Print)	**Phone:**
Physician's Signature	**Date:**

PART II – To be completed by parent(s)/guardian(s):

We (I), the undersigned parent(s) /guardian(s) of the student named above, make the following request and acknowledgements:

1. We requested the Specialized Health Care Service described above be provided to our child in the school setting in accordance with the policies and procedures of the Weimar Independent School District and as prescribed b our child's licensed physician.
2. We understand that, whenever possible, the specialized health care services are to be PROVIDED AT HOME BEFORE OR AFTER SCHOOL HOURS.
3. We will notify the school nurse immediately IF:
   - the health status of the above named child changes;
   - the physician changes; or
   - the requested procedure is changed or cancelled
4. We understand that the school administrator will designate a qualified person(s) who will perform or supervise this health care service.
5. We give permission for the exchange of confidential information between the school nurse and the prescribing physician regarding our child's health care needs.
6. We understand that it is our responsibility to provide all supplies and equipment necessary for this procedure.

Parent/Guardian's Name (Print)	Home Phone:	Work or Cell Phone:
Parent/Guardian's Signature		Date: