

**Houston Independent School District
Health and Medical Services**

REQUEST FOR PERFORMANCE OF TREATMENT AT SCHOOL BUILDING DURING SCHOOL HOURS

	<p>To the Principal of: _____</p> <p>Name of Child: _____ Birthdate: _____</p> <p>Address: _____ Telephone: _____</p> <p>Email Address: _____</p>
P H Y S I C I A N	<p>Diagnosis: _____</p> <p>Etiology: _____</p> <p>Date of onset: _____</p> <p>Prognosis: _____</p> <p>Type of procedures to be performed: _____ _____</p> <p>How often or at what time? _____ _____</p> <p>Specific recommendations: _____ _____</p> <p>Precautions, possible untoward reactions, and interventions: _____ _____</p> <p>Any other pertinent history or physical findings that may affect this procedure: _____ _____</p> <p>_____ Date _____ Physician's Signature</p> <p>_____ Physician's Address _____ Type or Print Physician's Name</p> <p>_____ Telephone Number</p>
P A R E N T	<p>I understand that I am giving consent for the school nurse to discuss any concerns regarding this treatment with the healthcare provider whose signature appears on this document.</p> <p>Should my child manifest any unusual symptoms, please contact _____ at _____ and/or my child's physician immediately.</p> <p>_____ Telephone number</p> <p>_____ Date _____ Alternative Telephone number</p>

Physician's request must be renewed at the beginning of each school year. Any change of treatment must be requested in writing by the physician.