Houston Independent School District
Health and Medical Services

REQUEST FOR PERFORMANCE OF TREATMENT AT SCHOOL BUILDING DURING SCHOOL HOURS

To the Principal of: _____

Name of Child: _____ Birthdate: _____

Address: _____ Telephone: _____

Email Address: _____

PHYSICIAN

Diagnosis: _____

Etiology: _____

Date of onset: _____

Prognosis: _____

Type of procedures to be performed: _____

_____

How often or at what time? _____

_____

Specific recommendations: _____

_____

_____

Precautions, possible untoward reactions, and interventions: _____

_____

Any other pertinent history or physical findings that may affect this procedure: _____

_____

_____ _____

Date Physician's Signature

_____ _____

Physician's Address Type or Print Physician's Name

_____

Telephone Number

PARENT

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.

Should my child manifest any unusual symptoms, please contact _____at_____ and/or my child's physician immediately.

_____ _____

Parent's Signature Telephone number

_____ _____

Date Alternative Telephone number

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.

Reviewed: 7/2023