## 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:		
Diagnosis:		
Etiology:		
Date of onset:		
Prognosis:		
Type of procedures to be performed:		
How often or at what time?	/ O./	_
		_
Specific recommendations:		
		_
		_
Precautions, possible untoward reactions, and interventions:		
Precautions, possible untoward reactions, and interventions:  Any other pertinent history or physical findings that may affect t		
Any other pertinent history or physical findings that may affect to the desired part of the desired part o	his procedure:Physician's Signature	
Any other pertinent history or physical findings that may affect t	his procedure:	_ _ _ _
Any other pertinent history or physical findings that may affect to the desired part of the desired part o	his procedure:Physician's Signature	
Any other pertinent history or physical findings that may affect to Date  Physician's Address  Telephone Number	his procedure:  Physician's Signature  Type or Print Physician's Name	
Any other pertinent history or physical findings that may affect to Date  Physician's Address	his procedure:  Physician's Signature  Type or Print Physician's Name	
Any other pertinent history or physical findings that may affect to Date  Date  Physician's Address  Telephone Number  I understand that I am giving consent for the school nurse to discuss any signature appears on this document.	his procedure:  Physician's Signature  Type or Print Physician's Name	wh
Any other pertinent history or physical findings that may affect to Date  Physician's Address  Telephone Number  I understand that I am giving consent for the school nurse to discuss any	Physician's Signature  Type or Print Physician's Name  concerns regarding this treatment with the healthcare provider	wh
Any other pertinent history or physical findings that may affect to Date  Date  Physician's Address  Telephone Number  I understand that I am giving consent for the school nurse to discuss any signature appears on this document.  Should my child manifest any unusual symptoms, please contact	Physician's Signature  Type or Print Physician's Name  concerns regarding this treatment with the healthcare provider	wh
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Any other pertinent history or physical findings that may affect to Date  Physician's Address  Telephone Number  I understand that I am giving consent for the school nurse to discuss any signature appears on this document.  Should my child manifest any unusual symptoms, please contact my child's physician immediately.	Physician's Signature  Type or Print Physician's Name  concerns regarding this treatment with the healthcare provider  at	who

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.

Rev.: 7/13/2010