Lewisville ISD Health Services

Request for School Personnel to Perform Medical Procedure

Student Name: _____

DOB: _____ School: _____

Name of Procedure: _____

Physical condition necessitating the procedure: _____

Times/frequency and indication for procedure: _____

_____

Beginning Date: _____ Ending Date: _____

Equipment/Supplies needed to be provided by parent: _____

_____

Precautions, possible untoward reactions, contraindications, and interventions (attach copies of emergency instructions): _____

Student may participate in Self-Care: _____ NO _____ YES

If YES: _____ Needs Supervision _____ Independent

Circumstances in which the physician is to be contacted: _____

_____

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I request and authorize the Lewisville ISD to perform the above procedure as prescribed. I understand the school administrator may designate any qualified employee to administer or perform the above-named procedure. I further understand that procedures that can be performed at home will not usually be done at school. I agree to notify the school immediately of any changes in the health status of this student or in the prescribed specialized procedure. I authorize the school's registered nurse to consult with the Prescribing Physician as identified below to clarify this procedure, or to discuss his/her response to the prescribed procedure as required by law, including, but not limited to, the Nurse Practice and Medical Practice Acts of Texas. I acknowledge that the Prescribing Physician identified below must be a licensed physician in the State of Texas, except that for the first two months that my child has transferred into Lewisville ISD from another state in the United States, the Prescribing Physician's orders may be from a physician licensed in that state. I understand that if the consent for the nurse and the doctor to consult regarding this procedure is not granted or is revoked, it may not be possible for school personnel to administer or perform the procedure as prescribed above. I acknowledge that I will be required to submit a new form for each school year my child is enrolled in Lewisville ISD, and that this form is only valid for one school year.

Parent/Guardian Signature: _____Printed Name: _____

Day Phone Number: _____ Email: _____ Date: _____

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Please provide for the services/procedures as described above. Contact this office if there are questions or concerns relative to these services or the student's response to them.

Prescribing Physician Signature: _____ Printed Name: _____

Date: _____ Office Number: _____ Fax Number: _____

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