

Spring Branch Independent School District

ELIGIBILITY REPORT

SCHOOL HEALTH SERVICES AND RELATED SERVICES

Physician's Statement for Administration of Special Health Care Services

(Complete one form for each service requested)

Student's Name _____ Grade __ Sex __ Age __ Birthdate _____

Parent/Guardian _____ School _____

*It is necessary that special health care services be administered during school hours in order to maintain this child's physical health, support school performance and/or transportation requirements.

Health Service prescribed _____

Condition for which service is prescribed _____

Frequency _____ Duration _____

Method of administration _____

Equipment needed _____

Equipment care method _____

Special instructions _____

Possible reactions _____

(Please contact child's parent/guardian or my office)

To the physician: Please *initial all* appropriate box(s) below.

I have reviewed/approved the attached standardized procedure as written.

I have reviewed/approved the attached standardized procedure with written modifications.

I have attached my alternate/additional procedure and/or recommendations.

To the physician: Indicate unlicensed personnel who may perform this service with indirect supervision

Nurse Assistant

Teacher

Classroom Assistant

Office Staff

Transportation Assistant

*I certify that this student is under my continuing care, which includes monitoring his/her continuing need for the services and any needed modifications of the services prescribed above.

*Licensed Physician's Name (Please Print)

*Licensed Physician's Signature (Original)

Address

Telephone

*Date

I hereby grant permission for the school nurse and/or other school personnel so designated to administer this health service to my child according to the physician's statement given above.

Date

Signature of Parent/Guardian

R: 10/97

Note: *Asterisk denotes items required by Special Education