

Spring Branch Independent School District

HEALTH SERVICES

Eligibility Report

Physician's Statement for Administration of Special Health Care Services

Student's Name _____ Grade _____ 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* the appropriate box below:

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

Signature of Parent/Guardian

Date

R: 04/03

* Denoted items required by Special Education