EAGLE MOUNTAIN – SAGINAW ISD

Health Services

PHYSICIAN STATEMENT REGARDING MEDICAL CONDITION AND/OR HEALTH CARE PROCEDURES DURING SCHOOL HOURS

(Authorization is required annually)

STUDENT NAME____ DOB__________

GRADE_____ SCHOOL_______________________________ TEACHER/ID____________

MEDICAL CONDITION/DIAGNOSIS: ____

PRECAUTIONS, SIGNS/SYMPTOMS, INTERVENTIONS:___________________________

____

PROCEDURE TO BE PERFORMED:____

INSTRUCTIONS/GUIDELINES____

____

____

TIME/SCHEDULE:____

TO BE PERFORMED BY SCHOOL PERSONNEL? *(circle)* YES NO

SPECIFY WHO MAY PERFORM THIS PROCEDURE: ______NURSE _____AIDE

LIST MEDICATIONS STUDENT IS TAKING:____________________________________

____

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT WOULD BE HELPFUL IN CARING FOR THIS STUDENT.

________________________________	________________________________
PHYSICIAN NAME PRINTED	**PHYSICIAN SIGNATURE**
________________________________	________________________________
ADDRESS	**PHONE NUMBER**

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I HERE BY REQUEST THAT THE ABOVE PROCEDURE BE PERFORMED AT SCHOOL.

PARENT/GUARDIAN SIGNATURE ______________________________________**DATE**________

12/07