ALDINE INDEPENDENT SCHOOL DISTRICT
14910 Aldine-Westfield Road • Houston, Texas 77032-3099 • (281) 449-1011

REQUEST FOR SPECIALIZED HEALTH CARE BY SCHOOL PERSONNEL

TO THE PRINCIPAL OF _____

NAME OF STUDENT_____ DATE OF BIRTH_____

Diagnosis _____

Etiology_____

Date of Onset_____Prognosis _____

Procedure(s) to be performed_____

_____

How often or at what time?_____Duration of treatment_____

Specific Recommendations _____

_____

Precautions, untoward reactions, interventions _____

_____

Pertinent history or physical findings that may affect this procedure_____

_____

Complete the following information if student is medically fragile and requires exceptional care (i.e. ventilator dependent).

Based on my examination, I recommend that this student receive skilled nursing care during the school day.

❑ Yes or ❑ No

If yes, my recommendation for skilled nursing care is as follows:

- ❑ Direct care by licensed staff (assisted by unlicensed persons as appropriate)
- ❑ Direct care by unlicensed persons under supervision of RN
- ❑ List procedures requiring the level of care indicated _____

_____

PHYSICIAN SIGNATURE_____Date_____

Type or Print Physician Name _____Phone_____

This is a Two Page Document. See Parent Consent Form.

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Dear Parent/Guardian,

Information from your child's physician must be renewed each school year. Any change to treatment must be requested in writing by the physician.
Please complete the following acknowledging the physician's information indicated .

I understand that this service is necessary in order to maintain optimal health and school performance. I further understand that a qualified designated person(s) will perform the health care services listed above and recommended by my child's physician.

I agree to notify the school immediately if my child's:

- health status changes.
- physician changes.
- procedure changes or is discontinued.

The school nurse may consult with my child's physician regarding pertinent health issues which affect the delivery of related health services.

PARENT(S) SIGNATURE _____

_____

PHONE _____

ADDRESS _____

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AUTORIZACIÓN PARA
ASISTENCIA MÉDICA ESPECIALIZADA

Estimado Padre/Guardián:

El historial médico de su hijo/a tiene que ser renovado cada año. Cualquier cambio en el tratamiento tiene que ser solicitado por escrito por el doctor.

Por favor lea y complete la forma abajo como reconocimiento del historial médico indicado al reverso de esta forma.

Yo _____ y _____

Entiendo que este servicio es necesario con el fin de mantener una salud y un rendimiento óptimos. Entiendo, además, que una persona/s calificada/s será asignada para prestar los servicios recomendados por el doctor de mi hijo/a e indicados en el reverso de esta forma

Me comprometo a notificar a la escuela inmediatamente si:

- el estado de salud de mi hijo/a cambia.
- el doctor de mi hijo/a cambia.
- los procedimientos médicos de mi hijo/a cambian.

La enfermera escolar puede consultar con el doctor de mi hijo/a sobre asuntos pertinentes relacionados con su salud que afecten la distribución de servicios.

FIRMA DEL PADRE/S _____

_____

TELÉFONO _____

DIRECCIÓN _____