KELLER INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES PHYSICIAN/PARENT
REQUEST
FOR ADMINISTRATION SPECIAL PROCEDURES

Following all applicable laws, the prescribed procedure may be performed by the School Nurse, LVN and or Unlicensed Employee. The prescribed procedure that is required during the school day will be administered on receipt of this completed form, along with any special equipment items.

Name of Student	Age	Grade	Phone
Address	City		Zip
Teacher		School	

1. Condition for which prescribed treatment is required:

2. Specific procedure:

3. Method of administration:

4. Precautions, unfavorable reactions:

5. Disposition of student following procedure, if applicable, i.e. rest, home, hospital, call doctor's office, Return to class:

DATE OF REQUEST | DATE OF TERMINATION

PHYSICIAN'S NAME | PHYSICIAN SIGNATURE

PHYSICIAN'S ADDRESS | PHYSICIAN'S PHONE NUMBER

PARENT/GUARDIAN NAME

I, the parent/guardian of _____, approve the above procedure to be administered to my child by KISD personnel:

SIGNATURE | RELATIONSHIP | PHONE | DATE