HEALTH SERVICES DEPARTMENT
PHYSICIAN'S REQUEST FOR SCHOOL HEALTH SERVICES

The Crowley Independent School District Health Services Department personnel or other designated employees shall provide specialized health procedures when required for students to remain in school.

These services shall be provided only upon:

1. Receipt of a signed Physician's Request for School Health Services (see below).
2. A Parent Request Form signed by the parent or guardian.
3. A release from liability signed by the parent or guardian (On the Parent Request Form).

* *

Name of Student:_____ School:_____

Based on my evaluation as a licensed physician, the above-named student requires the following health care service in order to be educated at school:

Name of procedure: _____

Physical condition for which procedure is to be performed:
_____

Effective from: _____ through: _____

Times scheduled and/or indication for procedure: _____
_____

Physician's orders: _____
_____
_____

Precautions, possible reactions: _____
_____

Circumstances in which the physician should be contacted: _____

Any Restrictions on Personnel Who Can be Trained by the Registered Nurse to perform the procedure: _____

Other _____

_____ _____
Name of Physician (print) Physician's signature

Address:_____

Telephone:_____ Date:_____

8/2020

DISTRITO ESCOLAR INDEPENDIENTE DE CROWLEY
DEPARTAMENTO DE SERVICIOS DE SALUD
PETICIOS DEL MEDICO A LOS SERVICIOS DE SALUD

El personal u otros empleados designados a los Servicios de Salud del Distrito Escolar Independiente de Crowley, proveerán procedimientos especializados de salud cuando el estudiante tenga la necesidad de estos servicios para poder permanecer en la escuela.

Estos servicios serán ofrecidos con:

1. El recibo de la petición a los Servicios de Salud del Distrito y firmado por el médico (ver parte inferior).

2. La autorización de los padres/tutor.

3. Una hoja firmada por el padre/tutor, que excluya al Distrito de toda responsabilidad (ver hoja adjunta).

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Name of Student:____________________________ School:_______________________________

Based on my evaluation as a licensed physician, the above-named student requires the following health care service in order to be educated at school:

Name of procedure:____

Physical condition for which procedure is to be performed:_________________________________

Effective from:________________________________ through:_____________________________

Times scheduled and indication for procedure:____

Physician's directions:____

Precautions, possible reactions:____

Circumstances in which the physician should be contacted:_________________________________

Please specify whether a nurse or other person, such as a teacher, can be trained to perform the procedure: Registered Nurse:____

Other:____

_________________________________ _________________________________
Name of Physician (print) Physician's signature

Address:____

Telephone:________________________________ Date:__________________________________