

**LOCKHART INDEPENDENT SCHOOL DISTRICT  
HEALTH SERVICES**

**AUTHORIZATION FOR ADMINISTRATION OF SPECIALIZED HEALTH  
CARE PROCEDURES**

Students who need specialized health care procedures provided during the school day must have, in writing, a physician's prescription and parental authorization.

Student: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of procedure: \_\_\_\_\_

Description of the procedure: \_\_\_\_\_  
\_\_\_\_\_

Time/interval procedure is to be done: \_\_\_\_\_

Amount – (if applicable): \_\_\_\_\_

Precautions and/or possible adverse reactions: \_\_\_\_\_  
\_\_\_\_\_

Discontinuation date: \_\_\_\_\_

Authorization for this procedure is required annually.

\_\_\_\_\_  
Physicians Signature

\_\_\_\_\_  
Date

.....  
I hereby give my permission for my child to receive the specialized procedure named above as prescribed by my child's physician.

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date