Gainesville ISD Health Services
Specialized Health Care Procedures
Physician's Authorization

Name of Student: _____ Date of Birth _____

Address _____

For the Physician:

1. Physical condition for which the standardized procedure is to be performed:
   _____
2. Name of standardized procedure: _____
3. Precautions, possible untoward reactions, and interventions: _____
   _____
4. Time schedule and/or indication for the procedure: _____
   _____
5. The procedure is to be continued as above until _____

_____
Physician's Signature Date

_____
Physician's Address Telephone

For the Parent

I hereby request that the treatment specified above be performed to the child named above. I hereby release Gainesville Independent School District from all legal responsibility or liability that may arise, pursuant to this request for the above named procedure for my child. I understand that the principal will appoint a qualified designated person(s) to perform the above mentioned health care service. Each GISD campus grades Pre K-12 have a full–time registered nurse. We understand that, whenever possible, the specialized physical health care service should be provided before or after school hours.

_____ _____
Signature or Parent or Guardian Date

Work phone _____Cell phone _____ Home phone _____