Belton ISD Health Services
Physician and Parental Authorization for School Health Services
School Year: Campus:

Student Last Name	**Student First Name**	**DOB**	**Grade/Homeroom**	Transportation: Rides bus #_____ ☐Car rider ☐ Walker

☐No ☐Yes Student in Special Education Program? ☐No ☐Yes Student in 504 Program? (School accommodations for those with chronic health conditions)	
Relevant Diagnosis/History	
Nutrition/Hydration Needs	
Elimination/Toileting/Skin Care Needs	
Mobility Needs	
Health Equipment/Supplies Parent to Supply at School	

Medications					
Name of medication	Dosage	Route	Time(s)	Reason for Medication	Length of time needed

Special Procedures/ Treatments Needed While at School

Emergency Plan	
If these warning signs/symptoms appear:	The action to take is this:

Please write additional orders on the back or attach additional sheets as needed.

PHYSICIAN/PARENTAL AUTHORIZATION			
Physician: Print Name	Physician Signature	Physician Phone	Date

I request that the above health care/ personal care services be administered to my child. I understand that a qualified designated person(s) will be performing the above-mentioned health care service and that they will be using a standardized procedure that I have reviewed. I will notify the school immediately if the health status of my child changes, if we change physicians, or if there is a change or cancellation of the health care service.

Parental Signature	Best emergency phone	Other phone	Date