TULSA PUBLIC SCHOOLS

HEALTH SERVICES

REQUEST FOR TREATMENT DURING SCHOOL HOURS

Name of Child _____ Date of Birth _____

Address _____

Etiology _____

Date of Onset _____

Prognosis _____

Procedure to be Performed _____

_____

Frequency _____

Precautions, possible untoward reactions, interventions _____

_____

Any other pertinent history of physical findings that may affect this procedure _____

_____

_____

Signature of Parent/Legal Guardian Or Person Responsible for Student's Care	Date	Physician's Signature (if required)	Date
Telephone #		Physician's Telephone #	

NOTE: Physician's request must be renewed at the beginning of each school year. Any change of treatment must be requested in writing.

COMPLETE NEW FORM FOR EACH PROCEDURE

HD 47