South Campus 1906 2nd St. Galena Park, TX 77547 North Campus 8325 Barbara Mae Houston, TX 77015
Phone 832-386-2090 Fax 832-386-2091

Diaper Cream/Ointment Authorization Form

& K L O G ¶ V 1 D P H	Date of Birth:
Name of Medication/Cream to be applied: (can state over the counter diaper rash cream)	
Times to be applied: ☐ When rash is present ☐ With every diaper change ☐ Other:	Amount to be applied:
Special Instructions:	

Reason for medication: For diaper rash prevention or treatment
Route: Topical
Storage: Room temperature

I authorize the use of the a bove diaper cream/ointment on my child.

_____ _____
Parent/Guardian Signature Date

_____ _____
Health Care Provider Signature Date

_____ _____
Health Care Provider Printed Date

_____
Health Care Provider Phone Number

New form must be filled out each school year

All requests are subject to GPISD approval and provision based on policy and procedure

A. THIS SECTION TO BE COMPLETED BY PARENT / LEGAL GUARDIAN

***Student Last Name:** _____ ***First Name:**_____ **Date of Birth:** ___/___/___

School:_____ **Grade:** _____ **Student ID:** _____

Parent/Guardian Name: _____ **Phone:** _____

School Nurse: _____ **Phone:** _____

I give Health Services/Nutrition Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below.

Parent Signature: _____ **Date:** _____

B. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN / PRESCRIBING MEDICAL AUTHORITY

***Does the child have a disability and/or anaphylactic/life-threatening food allergy?** ☐ YES ☐

C. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN / PRESCRIBING MEDICAL AUTHORITY

I certify that the above named student needs special dietary accommodations, as described above, because of the student's disability and/ or life-threatening food allergy or food intolerance/allergy, as indicated.

☐MD ☐DO ☐NP ☐PA

***Signature of Licensed Physician/Prescribing Medical Authority** Date

***Printed Name of Licensed Physician/Prescribing Medical Authority**

Phone Fax

Address

Send completed form to school nurse. *Please submit new Physician Request form each school year. Any change or discontinuation must be submitted in writing by the physician. Please allow two business weeks for processing. Scan completed forms to ALGRANT@galenaparkisd.com or call 832-386-1549 with questions or return to the scc86 (e)-6 Tw 8.0 0 R(1to)-1*

C. ESTA SECCIÓN DEBE LLENARLA UN MÉDICO LICENCIADO O LA AUTORIDAD MÉDICA PERTINENTE

Yo certifico que el estudiante que se menciona arriba necesita las modificaciones dietéticas descritas, dado que presenta una discapacidad o una alergia alimentaria severa provocada por alimentos que ponen en riesgo su vida, como ya se ha mencionado.

_____ ☐MD ☐DO ☐NP ☐PA

***Firma del doctor o autoridad médica** Fecha

_____

***Nombre del doctor o autoridad médica**

_____

Physician's Request for Special Accommodations for Formula & Infant Food

A. [illegible]

***Student Last Name:** _ ***First Name:**_ **Date of Birth:** _ /_ /__

School:_ **Age/Class:** _ **Student ID:** _

Parent/Guardian Name: __ _ **Phone:** _

School Nurse: _____ **Phone:** _____

I give Health Services/Student Nutrition Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below.

Parent Signature: __ **Date:** _

B. [illegible]

***Does the child have a disability and/or anaphylactic/life-threatening food allergy?** ´ [illegible] ´ [illegible]

If YES selected, form must be completed and signed by licensed physician.

***If YES, please describe the major life activities affected by the disability:** _

***MEDICAL DIAGNOSIS:** _

[illegible]

Formula Options:

Infant Supplement Foods: - Optional

C. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN / PRESCRIBING MEDICAL AUTHORITY

I certify that the above named r2 [illegible] AuEtt[illegible]