Carroll ISD Health Services
Parental Authorization- Behavior/ Mental Health

Parent please answer:
Special Ed services? yes / no
Active 504 plan? yes / no
I would like 504 information yes / no

Name:____ D.O.B.:_____________ Grade/Teacher:______________________
Parent/Guardian: ___________________________________ Phone: __________________________
Parent/Guardian: ___________________________________ Phone: __________________________
Transportation: ☐ Car rider ☐ Walker ☐ Drives self ☐ Rides bus # _________
Before/After school activities: ☐ Athletics ☐ Band ☐ Club: ______________ ☐ Tutoring ☐ Other____________________

Treating Physician: ___________________________________ Phone: _____________________________
Diagnosis/Significant Medical History/ Hospitalizations: ____
____
____
Medication at home: ____
Medication at school: ____
Height: __________ Weight: ____________ Allergies: ____
Nutrition Concerns: ____

Interventions at School:

- Medication at school: _______________ When: ____
- Height/ weight checks? ______________ How frequent? ____________________________________
- Quiet time at school may be needed ____
- Assist with breathing techniques/ relaxation techniques/ access to counselor as needed
- Supervise during/ after meals, as prescribed by physician
- Notify parent of any emergency needs-
  - Preferred hospital: ____
- Any other possible known needs at this time? ____
  ____

☐ **By checking this box, I authorize reciprocal release of information related to student's mental health diagnosis and management between the school nurse and my student's health care provider.**

Parent/guardian signature: ____ Date: _____________________________

Revised 5/11/2020