



Specialized Health Care Procedures Authorization and Release of Liability

Allen ISD authorized staff will do Gastric Tube Feeding / Intermittent Catheterization/ colostomy or ileostomy care / Oxygen Administration / Oral Suctioning / Tracheal Suctioning of a student when this service is requested by parents or legal guardians in writing **and when a written order from the student's physician including explicit instructions is received.**

_____, a student at _____, has
Student's Full Name School

_____ and requires the following procedure(s) during the school day:
Problem/Disability

- Gastric Tube Feeding Intermittent Catheterization Colostomy/ileostomy Care
 Oxygen Administration Oral Suctioning Tracheal Suctioning

I hereby request this service be provided for my child and I will furnish the necessary supplies. I understand this is a special service and this permission letter releases the Allen ISD of any responsibility or liability in performance of this procedure.

Executed on this _____ day of _____, 20_____.

Witness

Signature of Parent or Guardian

Given under my hand and seal of office this _____ day of _____, 20_____.

Notary Public