Physician Order for
Special Health Care

Name of Student:_____ Birth Date:_____ ID_____

1. Physical condition(s) for which the specialized procedure is to be done:_____

   _____

2. Name/description of specialized procedure:_____

3. Precautions, complications and needed actions:_____

   _____

4. Person(s) authorized to provide procedure: ____ School Nurse _____ Trained school staff _____ Student
5. Time schedule and/or indications for the procedure _____

   _____

6. The procedure is to be continued as above until: (maximum is one school year): _____. I need to review this procedure no later than:_____

Date Date

_____ _____ _____
Physician's Signature Physician's Name Printed Date

_____ _____ _____
Physician's Address Physician's Office Phone Physician's FAX

The RN may need to contact the physician in writing or by phone.

All authorizations expire at the end of the current school year.

I request that the procedure/treatment be performed to my child, named above. The physician explained to me the procedure, its purpose and possible complications. I understand that it is my responsibility to provide all necessary supplies.

_____ _____ _____
Parent/Guardian's Signature Daytime Telephone Date