Physician Order for
Vital Sign Documentation

Name of Student:_______________________________________ Birth Date:_________________

1. The above student is being treated for: ___________________________________

   ____

2. Name of procedure: **Vital Sign Documentation**

3. Procedure Information:

   The above student needs documentation of the following vital signs: (circle ones that apply)
   Heart rate
   Respirations
   Blood pressure
   Temperature
   Frequency or how often vital signs should be taken:
   ____

   and/or in the presence of the following symptoms
   ____

   Time of day it is to be performed:_______________________________
   Special instructions (i.e. parameters < or >)
   ____

   Recommendations if values are outside the above parameters
   Notify Parents
   Notify Physician
   Other (specify)______________________________________

4. This procedure is to be continued as above until:__________.
   Date

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

5. This procedure MUST be performed by licensed personnel **only.** Yes___ no___
   Be advised that RN's are not in the building every day and some of the procedures are done by trained unlicensed personnel. Please specify a person from your facility who can provide training for school personnel.

Name:____ Phone:_____________________
Note: RN may need to contact physician in writing or by phone.

Physician's Signature:___________________________________ Date:_______________________

Print Physician's Name:_________________________________ Phone:_____________________

Parent permission: I hereby request that the treatment specified above be performed to the above-name child.

_________________________________ ____________________ _____________
Signature of Parent/Guardian Phone Date