

HEALTH SERVICES

PHYSICIAN'S ORDERS FOR

SPECIAL NURSING CARE/MEDICAL TREATMENT

Name of Student _____ Birthdate _____

Parent's Name _____ School _____

In order for this student to attend school, it is absolutely necessary that the following service be performed during the school hours. If specific training or instructions is necessary, I am willing to participate in this.

Service necessary (include detailed specific instructions):

1. Time procedure/service to be performed: _____

2. Specific duties involved in service: _____

3. Emergency precautions: _____

4. Special equipment or environmental recommended: _____

5. I may be called by school personnel regarding the above service: _____

Date

Physician's Signature

Duration of Order

Printed Name

Phone

Address