PHYSICIAN'S ORDERS FOR SPECIAL NURSING CARE/RELATED MEDICAL TREATMENT PROCEDURES

Name of Student ______________________ B.D. ______________ Grade ________

Parent's Name ______________________ School ______________________

In order for this student to attend school, it is absolutely necessary that the following service be performed during school hours. I understand that school district personnel will not perform any related medical procedure which by law may only be performed by authorized medical personnel. If specific training, instruction, or supervision is necessary for school staff, I will be available for consultation.

Service necessary (include detailed, specific instructions): ______________________

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1. Time procedure/service to be performed:

2. Physician's orders for special nursing care: ______________________

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Date ______________

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Duration of order

Physician's signature ______________________

Printed name ______________________

Address ______________________

City ______________________ Zip ______________

Telephone number (__________) ______________________

White: School
Yellow: Physician
Pink: Parent

Formerly: Policy No. 3418 F2