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): ________________________

____

____

1. Time procedure/service to be performed:

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

____

____

____

____

____

Date ________________

____
Duration of order

White: School
Yellow: Physician
Pink: Parent

Physician's signature ________________________

Printed name ________________________

Address ________________________

City ________________ Zip ____________

Telephone number (______) ________________