

Licensed Medical Provider Order/Authorization for Health Care Services to be Performed at School

Attach Health Care Plan If Applicable

Student

Birth Date

Parent(s) Name

I. Describe Condition for which Procedure is Required

II. Describe Procedure(s) to be Performed

III. Time Schedule for Procedure

Procedure should be continued until (date)

IV. Precautions/Possible Adverse Reactions/Interventions

V. Describe Special Equipment Required (If Any)

VI. Describe Physical Limitations (If Any)

