

**Health Services
Roanoke County Public Schools
1760 Boulevard
Salem, VA 24153**

**PHYSICIAN'S ORDER
HEALTH PROCEDURES**

STUDENT _____ **DOB** _____

PARENT/GUARDIAN NAME _____

ADDRESS _____

SCHOOL _____ **PROGRAM** _____

SCHOOL YEAR _____

Medical history and diagnosis:

Treatment(s)/Procedure(s) (Include product names, dosages, frequency)

Comments or limitations/restrictions to be recognized by school staff:

May an educational paraprofessional trained by a Registered Nurse perform the procedure(s) in school? _____ YES _____ NO

PHYSICIAN'S SIGNATURE _____ **DATE** _____

NAME OF PHYSICIAN _____
(Please Print or Type)

ADDRESS _____ **PHONE** _____