Physician Orders for Specialized Health Care Procedures

School Year: ___________

STUDENT NAME: ________________________ DOB: __________________________
SCHOOL: ________________________________ STUDENT ID: __________________

1. **Physical condition for which the specialized health services are to be performed:**
   ____
2. **Name of standardized procedure (Please attach information required to understand the steps of this procedure):**
   ____
   ____
3. **Precautions, possible untoward reactions, and interventions:** ___________________________
   ____
4. **Time schedule and/or indication for the procedure:** __________________________________
   ____
5. **The procedure is to be continued as above until:** ____________________________________
   ____
6. **Other:** ____

__________________________________ __________________________
Physician Name (Please Print) **Physician Phone Number**

__________________________________ __________________________
Physician Signature **Date**

____
Physician Address

<u>TO WHOM IT MAY CONCERN</u>:

I hereby give my permission for exchange of confidential information requested above for my child, ____________________________________, between _______________________________________ and ____________________________________.

______________________________ ____________________
Signature of Parent/Guardian Date

<u>PLEASE RETURN TO</u>: Oakland Nurse
FAX: 770-513-6803

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