



Physician's Orders for Administration of Specialized Health Care Procedures

Date: \_\_\_\_\_

School: \_\_\_\_\_ Principal: \_\_\_\_\_

Name of Student: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

- 1. Student's diagnosis or physical condition which requires this procedure:
2. Name of special 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:

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

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To Whom It May Concern:

I hereby give my permission for exchange of confidential information contained in the record of my child, \_\_\_\_\_ between \_\_\_\_\_ Healthcare Provider and \_\_\_\_\_ School

Parent or Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_