CCF-637
6/99

CLARK COUNTY SCHOOL DISTRICT
Health Services Department

LICENSED HEALTH CARE PROVIDER'S ORDERS FOR HEALTH SERVICES AT SCHOOL

Student's Name: _____

School: _____ Date of Birth: _____

1. Diagnosis: _____
2. Name of treatment or procedure: _____
3. Licensed health care provider's orders (must include name, dosage, frequency and route as applicable):

4. Name of health care provider (please print): _____

   Provider's Signature: _____ Date: _____

   Address: _____ City/State/Zip: _____

   Phone Number: _____ Fax Number: _____

THIS FORM MUST BE COMPLETED YEARLY

PARENT/GUARDIAN REQUEST FOR HEALTH SERVICES IN SCHOOL

1. This procedure is necessary for my child to attend school and cannot be provided before or after school hours.
2. I request that the treatment be administered in accordance with the above licensed health care provider's orders. I will notify the school if the health status of my child changes, our licensed health care provider changes, or the procedure is changed or canceled.
3. I agree to provide clearly labeled, functional equipment and supplies. I also agree to provide verbal or written directions for use.
4. The school is authorized to secure emergency medical services for my child whenever the need for such services is deemed necessary.
5. I hereby give my permission for exchange of confidential information contained in the record of my chid between _____ (name of licensed health care provider) and the CCSD Health Services Department.

Parent/Guardian Signature: _____ Date: _____

Original: School
Copies: Parent/Guardian
Health Services Department
Cum or Confidential Folder