

**FEDERAL WAY PUBLIC SCHOOLS
HEALTH SERVICES**

TREATMENT ORDER FORM

Name of Student: _____

Birth Date: _____

Parent's Name: _____

Phone: _____

School: _____

In order for this student to attend school, it is absolutely necessary that the following procedure be performed during school hours. If specific training or instruction is necessary, I am willing to participate in this.

Service necessary (include detailed specific instructions): _____

1. Time procedure/service to be performed: _____

2. Training needed for non-medical person to perform this service: _____

3. Special equipment/supplies or environment recommended: _____

4. I accept responsibility for monitoring that adequate, safe arrangements are made for performance of above service.

5. I may be called by school personnel regarding the above recommendation.

6. I will be monitoring the ongoing health status of this patient and inform the school of any changes.

Physician's Signature: _____ Date: _____

Printed Name: _____ Phone: _____

Address: _____ Fax: _____

Duration of Order: _____

School Nurse: _____ Date: _____