



Healthcare Provider Order

Student Name: _____ Date of Birth: _____

Parent/Guardian: _____

Home Phone: _____ Work _____ Cell: _____

Provider Name: _____ Phone: _____

Diagnosis: _____

Order/Special Instructions at School: _____

This order is valid for:

☐ School Year 20__-20__

☐ Specific Dates: _____ to _____

Healthcare Provider Signature: _____ Date: _____

To Be Completed by Parent/Guardian

I understand my signature will expressly waive any liability on behalf of the school or Healthy Kids Clinic as a result of enactment of the above order. My signature will give permission for exchange of verbal and written communication between the Health Care Provider and School Nurse regarding my child's medical treatment/plan of care.

Signature of Parent/Guardian

Phone

Date