Physician Order for Special Health Care

Name of Student:___________________________Birth Date:_________ ID_____________

1. Physical condition(s) for which the specialized procedure is to be done:_________________

   ____

2. Name/description of specialized procedure:_______________________________________

3. Precautions, complications and needed actions:____________________________________

   ____

4. Time schedule for this procedure to be done at school. _____________________

   ____

5. The procedure is to be continued as above until: (maximum is one school year):

   __________________________(date)

______________________________	________________________________	__________
Physician's Signature	Physician's Name Printed	Date
______________________________	_________________________	________________
Physician's Address	Physician's Office Phone	Physician's FAX

The RN may need to contact the physician in writing or by phone.

All authorizations expire at the end of the current school year.

I request that the procedure/treatment be performed to my child, named above. The physician explained to me the procedure, its purpose and possible complications. I understand that it is my responsibility to provide all necessary supplies.

_______________________________	_________________________	_______________
Parent/Guardian's Signature	Daytime Telephone	Date