Physician Order for Nasal/Oral Suctioning

Name of Student:____ Birth Date:_________________

1. The above student is being treated for:

____

2. Name of procedure: **Nasal/Oral Suctioning**

   The parent is required to provide the necessary supplies.

3. Procedure Information:

   Time to be performed____

   and/or with the following symptoms___________________________________

   ____

   Equipment needed____

   ____

   Please attach detailed procedure protocols.

4. This procedure is to be continued as above until:________________
   Date

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

Be advised that RN's are not in the building every day and some of the procedures are done by trained unlicensed personnel.

Physician's Signature:_______________________ Date:_______________________

Print Physician's Name:______________________ Phone:______________________

Parent permission: I hereby request that the treatment specified above be performed to the above-name child. I give permission for the RN to contact the physician in writing or by phone.

__________________________________ ____________________ _____________
Signature of Parent/Guardian Phone Date