Health Services **Physician's Orders**

Name: _____ **DOB:**_____ **Student ID#:** _____
Campus: _____ **Grade:** _____

Diagnoses:

Allergies:

Physician's Orders

Physician's name (printed) | Physician's signature | Date

Physician's address | Physician's phone | Physician's fax

- I give permission for the above orders to be implemented for my child at school.
- I understand that the District, the Board, and its employees are not liable for damages or injuries resulting from implementation of the above orders.

Parent/guardian signature | Date