Health Services **Physician's Orders – Specialized Care**

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

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. Person(s) authorized to provide procedure: ☐ School Nurse ☐Trained School Staff ☐Student
   _____
5. Time schedule and/or indications for the procedure: _____
   _____
6. The procedure is to be continued as above until (maximum is one school year): _____
   I need to review this procedure no later than: _____

_____	_____	_____
Physician Signature	Print Name	Date
_____	_____	_____
Physician Signature	Telephone	Fax Number

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.

_____	_____	_____
Parent/Guardian Signature	Date	Daytime Telephone
_____	_____	
Student Signature (Assent if appropriate)	Date	
_____		_____
Goal of procedure		Estimated Time (hours/week)

I have reviewed the order for safe implementation. The date for review/renewal is: _____

_____	_____
School Nurse Signature	Date

I have accepted the order to be carried out by the School Nurse/School Staff/Student in my school.

_____	_____
Principal Signature	Date