Physician Orders for Special Health Services

Student Name _____**Date of Birth** _____

District/Building _____**Grade** _____

PHYSICIAN STATEMENT:

This student is under my medical supervision. I have prescribed the following treatment during the student's school day:

Activity level/ limitations:_____

_____

Medication *(Time, Dose, Route)* : _____

_____

Dietary recommendations/ restrictions: _____

_____

Feeding instructions/ restrictions:_____

_____

Procedure *(Schedule, equipment, special instructions, or indications*) : _____

_____

_____

_____

_____

_____

Procedure discontinue date _____**Follow-up date**_____

Anticipated reactions/possible side effects of treatment: _____

_____

_____

_____

Physician name *(print)* **Physician signature** **Date**

PARENT/GUARDIAN STATEMENT:

I request special health services, as described in these orders, be provided during the course of the school day. The school nurse has my permission to contact the prescriber if clarification is needed. I understand that qualified designated staff using standardized procedures will perform the special health services required.

Parent/ guardian signature _____**Date**_____