

**PHYSICIAN'S ORDERS FOR SPECIAL NURSING CARE/RELATED MEDICAL
TREATMENT PROCEDURES**

Name of Student _____ B.D. _____ Grade _____

Parent's Name _____ School _____

In order for this student to attend school, it is absolutely necessary that the following service be performed during school hours. I understand that school district personnel will not perform any related medical procedure which by law may only be performed by authorized medical personnel. If specific training, instruction, or supervision is necessary for school staff, I will be available for consultation.

Service necessary (include detailed, specific instructions): _____

1. Time procedure/service to be performed: _____

2. Physician's orders for special nursing care: _____

Date _____

Physician's signature _____

Duration of order

Printed name _____

Address _____

White: School
Yellow: Physician
Pink: Parent

City _____ Zip _____

Telephone number (_____) _____

Formerly: Policy No. 3418 F2