

NORTH HARRISON COMMUNITY SCHOOL CORPORATION

PHYSICIAN'S ORDER FOR TREATMENT

THIS SECTION TO BE COMPLETED BY PHYSICIAN:

STUDENT'S NAME: _____ **Date of Birth:** _____

DIAGNOSIS: _____

PRESCRIBED TREATMENT : _____

TIME SCHEDULE AND/OR INDICATION FOR TREATMENT : _____

PRECAUTIONS, POSSIBLE ADVERSE REACTIONS AND RECOMMENDED INTERVENTIONS: _____

Physician Check one:

- a. _____ I have reviewed and approved the attached standardized procedures as written.
- b. _____ I have reviewed and approved the attached standardized procedures with my modification.
- c. _____ I have attached my recommendations for standardized procedures.

Treatment to be continued as above until _____ (orders to be renewed each school year)
 Date

PHYSICIAN AUTHORIZATION

I authorize for the above named student to receive this treatment during the school day as indicated.

Physician's Signature: _____ **Date:** _____

Physician's Printed Name: _____

Physician's Phone No. _____

Physician's Address/City/State/Zip: _____

PARENT/LEGAL GUARDIAN AUTHORIZATION

As the parent/legal guardian of the above named student, I request, authorize, and give permission to provide the treatment described above to my child at school in accordance with the instructions provided. I authorize school personnel to exchange information regarding this treatment with the physician listed above. I agree to notify school personnel immediately of any change in the prescribed treatment with a revised physician's order for treatment from my child's physician.

Parent/Legal Guardian Signature: _____ **Date:** _____