Medical Orders for Specialized Health Care Procedures

Student:____**Birth date**:______________**ID**: __________

1. Physical condition(s) for which specialized procedure is to be done: _
____
2. Name / description of specialized procedure:____
____
3. Precautions, complications and needed actions: ____
____
4. Time schedule and/or indications for the procedure: ______________________________________
____
5. The procedure is to be continued as above until (maximum is one school year): ____________________

Print - Physician Name:________________________________**Telephone**: _______________________

Fax:____________________**Physician Address**:____

Physician Signature:____**Date**: _______________________

I request this service be provided for my child, named above, and I will furnish the necessary supplies. The physician has explained to me the procedure, its purpose and possible complications. I understand this is a special service, and this permission letter releases the Allen ISD of any responsibility or liability in performance of this procedure.

GOAL of procedure: ____

Parent/guardian signature:____**Date**: ______________

Daytime Telephone: ____

Student signature: ____
(if applicable)