NORTH HARRISON COMMUNITY SCHOOL CORPORATION

PHYSICIAN'S ORDER FOR TREATMENT

THIS SECTION TO BE COMPLETED BY PHYSICIAN:

STUDENT'S NAME: ______________________________ **Date of Birth:** __________

DIAGNOSIS:____

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PRESCRIBED TREATMENT:____

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TIME SCHEDULE AND/OR INDICATION FOR TREATMENT:______________________________

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PRECAUTIONS, POSSIBLE ADVERSE REACTIONS AND RECOMMENDED INTERVENTIONS:____

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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:** __________

THIS AUTHORIZATION IS VALID FOR NO MORE THAN ONE SCHOOL YEAR.