Charles City Public Schools
Tradition • Technology • Excellence

MEDICAL PROCEDURE ORDERS

School: _____ Grade: _____ Current School Year: _____

STUDENT INFORMATION

Student Name: _____ Birthdate: _____

Home Address_____
Street *City* *Zip*

MEDICAL INFORMATION

Licensed Medical Provider Name: _____ Title _____

Specialty: _____ Practice: _____ Phone: (_____)_____

MEDICAL ORDERS **Date of Order: _____** **Date to Discontinue: _____**

Procedure: _____

Frequency: _____ Time(s) of Administration: _____

Specific directions for procedure(s): _____

_____

_____

_____

Special side effects, contraindications, or possible adverse reactions: _____

_____

_____

Consent for self-administration by student (with approval of parent/guardian & school nurse): _____ Yes _____ No

The medical procedure(s) listed above are hereby requested and ordered by:

_____ _____ _____
Print Name of Medical Provider *Signature of Medical Provider* *Date*

PARENTAL CONSENT: *I request that the above listed procedure be given to my child _____.*
The medical provider explained to me the procedure, its purpose and possible complications.

_____ _____ _____
Print Name of Parent/Guardian *Signature of Parent/Guardian* *Date*