Y.A.L.E. School
PHYSICIAN'S ORDERS FOR SPECIAL NURSING CARE/RELATED MEDICAL TREATMENT PROCEDURES

As mandated by state law and as a means of giving proper care to your child we are requesting that the following form be completed and returned to school. This form should be returned with a copy of the physician's order written on a prescription for any treatments, specific procedures or medical monitoring that will be performed during the school day. Please use a separate form for each order.

Physician's Order **Date**_____

Student's Name: _____ DOB: _____

(Check One Below)

☐ Treatment: _____

☐ Procedure: _____

☐ Monitoring: _____

Time of Day: _____

Duration of Order: _____

Call the Doctor with the following: _____

In the event of an off campus outing, this treatment can be: (Please, check)
_____ Withheld for the day
_____ Performed up to _____ hours early
_____ Performed up to _____ hours late

Please notify the school when a treatment change occurs. Please contact the school to obtain information regarding this student's school performance to aid in further monitoring.

PHYSICIAN SIGNATURE REQUIRED

Physician's Signature _____

Printed Name _____

Address _____

_____

Telephone Number _____

I give permission for the school nurse to perform the above prescribed treatment for m y child. I will bring in any necessary equipment and/or supplies to the school which may be needed to perform the treatments.

SIGNATURE REQUIRED

_____
Parent/Guardian Signature

_____
Relationship to Student