CLOVER SCHOOL DISTRICT
SPECIALIZED HEALTH CARE PROCEDURES

Student's Name _____ DOB_____
School _____ Teacher _____Grade/Sec_____

PHYSICIAN'S ORDER – REQUIRED

Diagnosis: _____
Name of Procedure: _____
Procedure Time/Schedule: _____

Specific Orders for Administration (Or Attach Written Orders):
1._____
2._____
3._____
4._____
5._____
6._____

Start Date: _____ Stop Date: _____
Is student able to self-perform procedure? _____

Physician's Signature _____ Date _____

TO BE COMPLETED BY PARENT/GUARDIAN

I request that my child, _____ be administered the above stated procedure as directed and release Clover School District, its employees or agents from any claims or suits related to administration of the procedure as prescribed. I understand that this procedure/service will be evaluated by the school nurse and may be delegated to non-licensed personnel. I understand that the person(s) performing/supervising the above health care procedure will be following the written order prescribed by the healthcare provider. I understand it is my responsibility to provide any supplies needed, inform the school immediately if there are any procedure changes or discontinuation, and obtain a new from if order changes. I give permission for the school nurse to contact the Healthcare provider to discuss my child's health or procedure.

Parent/Guardian Signature_____ Date _____