



**Medical Provider Orders – Procedures**  
**20\_\_\_\_ - 20\_\_\_\_**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ School: \_\_\_\_\_

Parent/Student requested procedure(s) during school hours: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER WITH PRESCRIPTIVE AUTHORITY:**

<b>Student's Diagnosis:</b>
<b>Physical condition for which the procedure is to be performed:</b>
<b>Medical orders for procedure(s):</b>
<b>Time schedule and/or indication for the procedure:</b>
<b>The procedure is to be continued as above until (date):</b>
<b>Precautions and/or reactions the physician wishes to be notified of:</b>

\_\_\_\_\_  
Signature of Healthcare Provider with Prescriptive Authority

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Name of Healthcare Provider

\_\_\_\_\_  
Telephone Number

I authorize this procedure to be performed by the school nurse or the nurse's designee. I agree to provide the needed supplies for the procedure and understand that new permission forms must be completed annually or with any change to my child's health status. I give permission for the nurse or the nurse's designee to administer the procedure as described above and give my permission for the Healthcare Provider to share information about this procedure with the school nurse or nurse's designee. The undersigned parent(s)/guardian(s) hereby agree(s) to exempt and release the Elizabeth School District, its directors, officers, employees, volunteers, and agents from any and all liability, claims, demands or actions arising out of any damage, loss, or injury that my child or I/we sustain arising out of the administration of this procedure(s).

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date