Physician's Authorization for Treatment to be Performed in Chesapeake Public Schools

Name of Student: DOB:

Address:

Physical condition for which the standardized procedure is to be performed:

Name of standardized procedure:

Specific treatment instructions:

Precautions, possible untoward actions, and interventions:

Time schedule and/or indications for the procedure:

Duration of order:

Physician's signature: Date:

Address: Phone #:

Parent or Legal Guardian,

I request the school nurse or other authorized personnel to give the above treatment as ordered by the physician.

Signature of Parent/Guardian:

Address of Parent/Guardian:

Date:

School Student Attends: Student's Name:

Witness:

Title of Witness:

Address of Witness:

Revised 2/19