



RACINE UNIFIED SCHOOL DISTRICT
Health Services
Procedure at School

PARENT/GUARDIAN REQUEST:

Student's Name: _____ Date of Birth: _____
Please Print

Parent/Guardian's Name: _____ Date Requested: _____

I request that my child, named above, receive the following procedure at school using the doctor's orders written below. I give permission for the school nurse to contact the doctor or the doctor's representative to clarify any questions about the procedure. I understand that this procedure requires a new order each school year or if there is any change. I understand that I am responsible for providing all supplies related to this procedure.

Procedure: _____ **Latex Allergy:** YES NO

Parent/Guardian's Signature: _____

PHYSICIAN'S ORDERS:

Student's Name: _____ Date of Birth: _____

Physician's Name: _____ Phone Number: _____

Address: _____ Fax Number: _____

I authorize that the student named above receives the procedure listed below at school per the orders below. I understand that a school district employee(s) trained by the school nurse following school district protocols will perform or assist with the procedure as needed.

Length of Order: Full School Year/Summer School From _____ to _____

Type of Procedure: _____

Procedure is: Clean Sterile

Latex Precautions: Yes No

Frequency of Procedure: _____

Student Needs: Someone to perform the procedure for them Assistance Only Independent

Does this order replace a previous order: No Yes If yes, the previous order will be discontinued.

Comments: _____

Physician's Signature: _____ **Date:** _____
