EAST TROY
COMMUNITY SCHOOL DISTRICT

MEDICAL ORDER FOR SPECIALIZED HEALTH CARE PROCEDURES

☐ Leona Doubek Elementary	☐ Prairie View Elementary	☐ East Troy Middle School	☐ East Troy High School
Phone: 262-642-6730	Phone: 262-642-6720	Phone: 262-642-6740	Phone: 262-642-6760
Fax: 262-642-6723	Fax: 262-642-6788	Fax: 262-642-6743	Fax: 262-642-6776

Last Name:_____ First Name:_____ Date of Birth:_____ ☐M ☐F

Parent's Name:_____ Home #:_____ Cell #:_____

Physician's Name:_____ Phone #:_____ Fax #:_____

Physician's Address:_____ City:_____ St:_____ Zip:_____

TO BE COMPLETED BY THE PHYSICIAN

Physical condition for which the procedure is to be done:_____

Description of procedure:_____

Precautions, complications and needed actions:_____

Goals of procedure:_____

Authorized person(s) to provide procedure:_____

Time/Indication for procedure:_____

Continue procedure until (one (1) school yr max):_____

Physician review procedure no later than:_____

Special Instructions:_____

Physician's Signature:_____ Date:_____

TO BE COMPLETED BY THE PARENT/GUARDIAN

I request the procedure/treatment be performed to my child, named above. The physician explained to me the procedure, its purpose and possible complications.

Parent/Guardian's Signature:_____ Date:_____

Student's Signature (assent):_____ Date:_____

TO BE COMPLETED BY THE SCHOOL NURSE

I have reviewed the order for safe implementation. The review/renewal date is:_____

Estimated hrs/week to perform procedure:_____ Approx. number of times performed/week:_____

I have trained the following staff to perform this procedure:

Name:_____ Name:_____

School Nurse's Signature:_____ Date:_____

TO BE COMPLETED BY THE PRINCIPAL

I have accepted the order to be carried out by the school nurse/staff/student in my school.

Principal's Signature:_____ Date:_____