BLUE SPRINGS SCHOOL DISTRICT
SPECIALIZED CARE PROCEDURES AND PHYSICIAN ORDERS

Student Name: _____ DOB: _____ Grade: _____

Medical Diagnosis: _____

Treatment/Procedure (include frequency): _____

_____

_____

_____

Precautions/Recommendations: _____

_____

_____

_____

_____ _____
Physician Signature Date

_____ _____
Parent/Guardian Signature Date

WRITTEN ORDERS MUST BE RENEWED EACH SCHOOL YEAR