BLUE SPRINGS R-IV SCHOOL DISTRICT

SPECIAL CARE PROCEDURES AND PHYSICIAN ORDERS

Name: _____ DOB: _____ School: _____ Grade: _____

Address: _____

Medical Diagnosis: _____

Treatment/Procedure (include frequency): _____

_____

_____

_____

Precautions/Recommendations: _____

_____

_____

_____

_____ _____

Physician Signature Date Parent/Guardian Signature Date

WRITTEN ORDERS MUST BE RENEWED EACH SCHOOL YEAR