Leander Independent School District
Medical Orders for Specialized Health Care Procedures

Student's Name: ___________________________________ Grade: _________ ID#________________

1. Physical condition(s) for which specialized procedure is to be done: ____________________________

   ____

2. Name/description of specialized procedure: ____

   ____

3. Physician's specific instructions or how procedure is to be performed: ___________________________

   ____

   ____

4. Precautions and/or complications to watch for: ____

   ____

   ____

5. Person(s) authorized to provide procedure: _______ School Nurse/Clinic Assistant

   _______ Trained teacher or staff member _______ Other (please specify) ____________________

6. Time schedule and/or indications for procedure: ____

7. Procedure to be continued as above until (maximum is one school year): _________________________

____ ____

Physician's Signature Printed Physician's Name

__________________________ __________________________ __________________________

Date Phone Fax

I request the above procedure be administered to my child. I agree to furnish the school with the necessary supplies and equipment. The physician explained to me the procedure, its purpose and possible complications.

____ ____

Parent/Guardian Signature Date

Goal of Procedure: ____

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

____ ____

RN Signature Date

I am aware of the order to be carried out by the School Nurse, Clinic Assistant and/or trained staff member.

____ ____

Principal Signature Date