

SYRACUSE CITY SCHOOL DISTRICT
HEALTH SERVICES

DOCTORS ORDER FORM

SCHOOL _____ SCHOOL NURSE _____
PHONE NO. _____

In order for the school nurse to provide necessary nursing care for the following student, we are requesting the following form be filled out as completely as possible.

STUDENTS NAME _____
DATE OF BIRTH _____
ADDRESS _____
HOME PHONE _____

PRINCIPAL DIAGNOSIS _____

PERTINENT DIAGNOSIS _____

TREATMENTS OR PROCEDURES – Please include all indicated dressing changes, respiratory treatments, nutrition procedures, toileting, catheter or ostomy care.

Necessary equipment/supplies provided by: _____ Self _____ Other _____

MEDICATIONS:
NAME OF MEDICATION _____
DOSE _____
FREQUENCY _____
ROUTE _____

PARENT SIGNATURE _____

ATTENDING PHYSICIAN – SIGNATURE _____
DATE _____

ATTENDING PHYSICIAN (Please type or print)
NAME _____
ADDRESS _____
PHONE # _____