Physician's Order for Specialized Health Care Procedure

Student's Name:_____ Birth Date:_____ Age:_____

Address:_____
Street *City* *State* *ZIP*

The above student requires the following specialized services from the Forsyth County School District:

	Procedure:	**Diagnosis and description of the medical condition for which the specialized serves are needed.**
☐	Tube Feeding	
☐	Clean Intermittent Catherization	
☐	Ostomy Care	
☐	Oxygen	
☐	Tracheostomy	
☐	Trachael Suctioning	
☐	Nose/Mouth Suctioning	
☐	Ventilation	
☐	State of health is tenuous to the point of being life-threatening	
☐	Congestive Heart Disease	
☐	Apnea Monitoring	
☐	Life-threatening Respiratory Infections	
☐	Other	

Describe the medical facts that support the student's need for the requested services:

_____

_____

_____

_____

Date Condition Began: _____ Estimated Duration or Ending Date: _____

Practice Name: _____ Telephone Number: _____

Address: _____

Examiner's Name (Please Print): _____ Credentials: _____

Examiner's Signature: _____ Date: _____

Revised: July 2023