CAMPBELLSPORT SCHOOL DISTRICT

This order for procedures is required to be completed and presented to the school a child attends before any procedure that may be performed to the child.

Name of Student _____ Address_____ Phone _____

School _____ Grade _____

Physician's Name _____ Physician's Address _____

Diagnosis _____

Procedure: Daily or as needed (PRN).

Procedure		Given	Duration	Indicate condition under which med. Should be given. (PRN med. only)	Physicians: Please list condition or adverse reactions which indicate parental and/or physician notification.

I hereby give my permission to the persons designated below to perform procedures listed above to my child according to the directions stated above and further authorize them to contact my child's physician. I agree to hold the Campbellsport School District, its employees and agents, who are acting within the scope of their duties, harmless in any and all claims arising from the procedures performed at school.)

I agree to notify the school in writing when any change in the above order is made.

Signature of Parent/Guardian _____ Date _____

Physician's Signature _____ Date _____