Loudoun County Public Schools
Provider / Physician’s Order for Medical Procedure

Student’s Information

Last Name: ___________________  First Name: ________________  DOB: ______
Student ID # ________________  School: ________________  Grade: ______
Parent/Guardian: ________________  Cell: ________________  SY: ______
Email: ________________________________

☐ Medical Procedure  ☐ Student Health History

The following is to be completed by a physician/licensed medical provider:

Diagnosis/Medical Condition: ____________________________________________
Pertinent Health History: __________________________________________________
Recommendations for school: _____________________________________________

Physician’s Order for Specific Procedure. Please indicate times if necessary:

Healthcare Provider’s Name (Print/stamp): ________________________________
Healthcare Provider’s Signature: _________________________________________
National Provider Identifier (NPI): _________________________________________
Date: ______________________  Phone: ___________________________

Parent/Guardian Name: _________________________________________________
Phone: ______________________

My signature gives permission for principal’s designee to follow this plan, administer prescribed medication, and contact healthcare provider if necessary. I also agree to pick up any unused medication at the end of the school year. I understand that medication not picked up by a parent/guardian at the end of the school year will be discarded.

Parent/Guardian Signature: _____________________________________________
Date: ______________________

Medication Provided Date: _____________________________________________

August 6, 2019
CK/JK