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

Place Student's Picture Here

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: _____	Date: _____
National Provider Identifier (NPI): _____	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