

**BLUE SPRINGS SCHOOL DISTRICT
SPECIAL CARE PROCEDURES AND
PHYSICIAN ORDERS**

Student Name: _____ DOB: _____ Grade: _____

Medical Diagnosis: _____

Treatment/Procedure (include frequency): _____

Precautions/Recommendations: _____

Physician Signature

Date

Parent/Guardian Signature

Date

WRITTEN ORDERS MUST BE RENEWED EACH SCHOOL YEAR