



School Health Order Form

To be completed by the Physician/Licensed Healthcare Provider

(Parents/Guardians: This information will be utilized by the School Health team to provide the prescribed services to your student)

Student's Name _____ D.O.B. _____

School _____ Teacher _____ Grade _____

CURRENT DIAGNOSIS / CPT Code and MEDICAL STATUS (additional information may be attached):

Medications: _____

Recommendations for Student Integration Into the school setting:

Activity Restrictions / Limitations _____

Accommodations _____

Nutritional / Dietary _____

Adaptive / Physical Education _____

Physical Therapy _____

Occupational Therapy _____

Special Procedures (including diapering) _____

Return to Clinic _____

Physician's Signature _____ **Date** _____

Physician (Print) _____ **NPI#** _____

Office # _____ **Fax #** _____