

**Bedford County Public Schools
Healthcare Provider Order for Health History/Procedure**

Student Information: Parent/Guardian to Complete

Student Name: _____ Grade: _____
DOB: _____ Age: _____ ID #: _____ School: _____

Student Health History/Medical Procedure: Licensed Healthcare Provider to Complete

Diagnosis/Medical Condition:

Pertinent Health History:

Medications Taken at Home & School (Complete the Medication Authorization Form for medications to be given at school):

Recommendations for School:

Specific Procedure to be Performed at School (Please indicate times if needed): N/A See Tube Feeding Order

Bedford County Public Schools Healthcare Provider Order for Health History/Procedure

Healthcare Provider Signature: _____ Date: _____

Healthcare Provider Printed Name/Stamp: _____

Healthcare Provider Phone #: _____ NPI #: _____

Healthcare Provider Address: _____

Parent/Guardian Authorization

My signature gives permission for the principal's designee to follow this plan and contact the healthcare provider if necessary. I also agree to pick up any unused supplies at the end of the school year. I understand that supplies not picked at the end of the school year will be discarded.

Parent/Guardian Signature: _____ Date: _____

Supplies/Equipment Received	Supplies/Equipment Picked Up
Date: _____	Date: _____
Staff Initials: _____ Parent/Guardian Initials: _____	Staff Initials: _____ Parent/Guardian Initials: _____