



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Student ID#: \_\_\_\_\_

Campus: \_\_\_\_\_ Grade: \_\_\_\_\_

**Diagnosis:**

---

---

**Allergies:**

---

---

**Physician's Orders:**

---

---

---

---

---

---

---

---

---

---

**Notes:**

---

---

---

---

---

---

---

---

---

---

---

Physician's name (printed) Physician's signature Date

---

Physician's address Physician's phone Physician's fax

- I give permission for the above orders to be implemented for my child at school.
- I understand that Melissa ISD, the Board, and its employees are not liable for damages or injuries resulting from implementation of the above orders.

---

Parent/Guardian signature Date