Prince George's County Public Schools
Department of Student Services
OFFICE OF SCHOOL HEALTH

Prescriber's Orders for Specialized School Health Services

School: ____________________ **School Year:** __________

Name of Student ____________________ (DOB: ________)

REFERRAL	Health Services Nurse		Phone
	Physician's Name		Phone
	Physician's Address		
PATIENT INFORMATION	Patient Name (Last, First, Middle Initial)	Date of Birth	Race
	Patient Address	Sex ❐ Male ❐ Female	Phone
	Parent or Guardian	Relationship to Child	Phone
	School Presently Attending		Phone
PHYSICIAN'S ORDERS	Diagnosis/Pertinent History (Use back as needed)		Treatment Start Date
			Treatment End Date
	Describe Treatment/Procedure to be Administered		
	Equipment/Supplies Necessary for Procedure		
	Dietary Recommendations		
	Activity Limitations		
	Physician's Signature		Date
PARENT/GUARDIAN	• I understand that I must supply the school with the equipment/supplies listed above. • I hereby authorize the treatment/procedure described above to be administered by Prince George's County Public School's staff to my child as directed by my child's physician. • I understand that the physician will be called if a question arises about my child's procedure.		Date
	Parent Signature		Date
PGCPS	RN/LPN Signature		Date

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