Prince George’s County Public Schools  
Department of Student Services  
OFFICE OF SCHOOL HEALTH  
Prescriber’s Orders for Specialized School Health Services

<table>
<thead>
<tr>
<th>School: __________________________</th>
<th>School Year: __________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Student __________________</td>
<td>(DOB: __________)</td>
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</tbody>
</table>

### 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**:
- **Parent or Guardian**:
- **School Presently Attending**:

### PHYSICIAN’S ORDERS
- **Diagnosis/Pertinent History (Use back as needed)**:
- **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.** [ ] Date: __________
- **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.** [ ] Date: __________
- **I understand that the physician will be called if a question arises about my child’s procedure.** [ ] Date: __________

### PGCPS
- **RN/LPN Signature**: [ ] Date: __________

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