PRESCRIPTION FOR NURSING/HEALTH SERVICES

Student Name: ______________________________

Date of Birth: ______________________________

Attending School District: ______________________________

Name of Specific Medical Procedure: ______________________________

Conditions for which Specific Medical Procedure is being prescribed: ______________________

If tube feeding, please indicate type of formula and amount to be given at each feeding: ____________

Frequency and duration of prescribed treatment (*i.e. prior to meals*): ______________________

Restrictions and/or important side effects/interventions: ______________________________

Reactions to be reported to physician? Yes ☐ No ☐ Describe: ______________________

This prescription is valid for one year from the signature date below.

____
Physician Signature (*stamped signature not valid*)

____
Date

____
Physician Name (Please Print)

NPI# ______________ Are you enrolled as a Medicaid provider? ☐ Yes ☐ No

Parent/Guardian Authorization

I hereby request that school personnel give my child ______________________ the Specific Medical Procedure ordered above by the physician and will not hold the Board of Education or its personnel responsible for complications related to the medication pursuant to P.A. 451 or 1976-S1178. Staff may contact the physician regarding administration of the medication if necessary.

____
Parent/Guardian Signature

____
Date

____
Parent/Guardian Name (*Please Print*)

310 Thomas Street, Allegan, MI 49010 - Phone 269.673.2161 - Fax 269.673.2361