



ADDITIONAL MEDICAL ORDERS
(Use for orders not written on other order forms)

Student Name: _____ **Date of Birth:** _____

Physician/Licensed Health Care Clinician Name (printed) _____

Phone (____) _____ **Fax** (____) _____

Address: _____

CLINICIAN SIGNATURE _____ **Date:** _____

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PARENT/GUARDIAN PERMISSION:

I hereby give my permission for the school nurse, supplemental trained staff or trained school employee(s) to carry out the above orders for my child (named above) during school hours. These orders have been prescribed by a licensed physician or other health care clinician.

PARENT/GUARDIAN SIGNATURE: _____ **Date:** _____

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School Nurse Signature _____ **Date:** _____