



**MEDICAL PROVIDER ORDERS
FOR SCHOOL BASED NURSING SERVICES**

These orders are for use by the GFPS School Nurse to provide medical care during the school day.

Patient's Name: _____

DOB: _____

Medical Intervention/Treatment: _____

Time: _____

Purpose: _____

Other instructions: _____

Physician Signature

Date

Parent Information/Permission: The staff responsible for _____

has my permission to provide the above specified services.

Parent/Guardian Signature

Date

Parent: Please list below any medications not listed above that are taken at home whether they are prescription or over the counter medications. This information is required in the event of an emergency medical situation while at school.

Before emergency medical services can be performed it is important to know what medication the child may have taken that day.

Medication: _____
