Do not alter Essex County Forms they have been designed to meet State and Federal requirements.

HEALTH DEPARTMENT
Children's Services Unit

Prescription for Preschool Based Related Services

(A separate prescription is required for each service)

Student's Name: DOB

District: School:

The child named above has been recommended for the following service by his/her school district:

Service/Therapy **(please check one)** ☑	**Period of Service** **(IEP Dates)**	**Frequency and Length of Service** **(ex. 2 X 45)**
☐ OT ☐ PT ☐ ST ☐ *NU ☐ CSL	From to	

* In addition to the prescription a specific Dr.'s order with detailed instructions is required.

ICD 10 Code	
Diagnosis	
Purpose of treatment	

Physician/Physician's Assistant/Nurse Practitioner Information **(please print or use stamp):**

Name:
Address:
Phone Number:
License Number/NPI #:

Physician/Physician's Assistant/Nurse Practitioner **Date:**

(Must be original signature)