

**Parent Request and Physician's Order Form
Wake County Public School System**

To be completed by parent:

Child's Name _____ Age _____ School _____

I request that my child be administered the medication as indicated in the physician's order below. I understand that non-medical personnel conduct the administration. If an emergency injection is ordered, I give permission for the School Nurse to instruct designated staff in the administration technique. I understand that it is my responsibility to transport the medication to school unless special arrangements are made with the principal.

I authorize the release and exchange of medical information between my child's physician, school nurse and Wake County Public School System that is necessary in carrying out this service for my child.

Parent/Guardian Signature _____ Telephone/Cell _____ Date _____

Para ser completado por padre:

El Nombre del niño _____ La edad _____ La escuela _____

Solicité que mi niño sea administrado la medicina como indicado en la orden de medico abajo. Entiendo que eso personal no medico conduce la administración. Si una inyección de la emergencia se ordena, doy el permiso al Enfermero de Escuela para instruir el personal designado en la técnica de la administración. Entiendo que soy mi responsabilidad de llevar la medicina para educar a menos que los arreglos especiales se hagan con el director.

Autorizé la liberación y el cambio de información médica entre mi medico de niño, enfermero de escuela el sistema Escolar Público del Condado de Wake que es necesario en se lleva a cabo este servicio para mi niño.

El padre/Firma de guardian _____ Teléfono/Celular _____ la Fecha _____

To be completed by doctor:

The child indicated above must have the medication listed during school hours in order to function at school.

Name and form of medication _____ Dosage _____ Hours to be given _____

Method of administration _____

Administration by Student School Personnel

Side effects to watch for: _____

Duration of order _____

Telephone _____ Physician's Name (Please type or print) _____ Physician's Signature _____ Date _____

To be completed by school:

Persons Administering Drug

Name _____ Title _____

Name _____ Title _____

Name _____ Title _____

Approved by _____ Signature of Principal _____ Date _____

Request For Medication Administration at School

To be completed by physician:

Name of Student: _____ DOB: _____

Medication: _____ Dosage: _____

Time(s) medication is to be given: _____ a.m. _____ p.m. _____

To be given from (start and stop dates) : _____ to _____ **OR** (check) _____ Current School Year

Significant Information (include side effects, toxic reactions, omission reactions): _____

Medical Conditions being Treated: _____ Contraindications for Administration: _____

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

a. Contact me at my office _____ Telephone _____

b. Take child immediately to the emergency room at _____

FOR SELF-ADMINISTRATION

Student has demonstrated understanding of and the ability to carry and self-administer the asthma medication, diabetes medication, or medication for anaphylactic reactions prescribed above.

Asthma medication - MDI (*Medicated Dose inhaler*) - MDI with spacer; Diabetes Medication - Insulin

Allergic/Anaphylactic reaction medication - Epinephrine Auto-injector

Parent/ Guardian must provide an extra inhaler to be kept at school in case of an emergency and the student must have a "Student Agreement For Self-Carried Medication" form completed and reviewed by the school nurse or designee.

A written statement, treatment plan and written emergency protocol developed by the student's health care provider must accompany the authorization form for students to self carry and administer rescue medication in accordance with requirements stated in G. S. 115C-375.2. Standard forms for most common diagnosis may be obtained from the school secretary or school nurse.

All medication for use at school must be delivered by parent/guardian in a container properly labeled by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

Physician's Signature

Date

Parent Permission

I hereby give my permission for my child (named above) to receive medication during school hours. A licensed physician has prescribed this medication; therefore, I hereby release the Harnett County School Board and their agents and employees for all liability that may result from my child taking the prescribed medication. I consent for the medical provider to disclose health or medical information regarding the above prescribed medication. This consent is good for the current school year unless revoked in writing

Parent/Guardian's Signature

Daytime Telephone Number(s)

Date

(School Use Only)

Approved by : _____
Principal's Signature

Date

Reviewed by: _____
School Nurse's Signature

Date