

**Parent Request and Physician's Order Form for Medication
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 Based Public Health 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 understand that:

- No local board of education and its employees and agents shall be liable in civil damages to any party for any act authorized or for any omission relating to that act, unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing.
- Information shared may be in the form of an emergency or individual care plan for my child and may include information provided by my child's physician, myself, or from records that have been released to the school from another agency.
- Exchange of information will be limited to the minimum necessary to provide the required assistance for my child and will be shared only with those staff who may need to provide the specified assistance for him/her.
- This consent to release information must be signed before my child's teachers can provide assistance with special medical needs other than notifying parents and providing Emergency Services (911).
- If my child participates in WCPSS before/after-school activities/sports, I will assume responsibility for contacting the advisor/coach of my child's medical condition. Since the medication kept by the school is only available during regular school hours, I will provide extra emergency medications that may be needed during the activity. I may contact the school nurse if assistance is needed in instructing the advisor in a medical procedure or if a copy of the information needs to be shared with them.

I authorize:

- The release and exchange of medical information between my child's physician, school nurse and Wake County Public School System (WCPSS) that is necessary in carrying out services for my child.

Parent/Guardian Signature _____

Telephone/Cell _____

Date _____

To be completed by physician: (please write legibly using layman's terms)

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

Name and form of medication _____

Dosage and time to be given _____

Symptoms to be given for _____

Method of administration _____

Administration by School Personnel Student *

*** Physician and parent must complete both sides of this form for an independent student. This student will not need adult supervision for asthma and/or anaphylaxis management and will carry and self-administer prescribed emergency medication.**

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 Medication

_____ Name	_____ Title	_____ Name	_____ Title
_____ Name	_____ Title	_____ Name	_____ Title
_____ Name	_____ Title	_____ Name	_____ Title

Approved by: _____

Signature of Principal _____

Date _____