Wake County Public School System
Form 1702
Parent Request and Physician's Order Form for Medication

To be completed by parent:

Student Name _____ **DOB** _____ **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.
Diagnosis: _____

_____ _____
Name and form of medication | Dosage and time to be given

_____ _____
Symptoms to be given for | Method of administration

Administration by ☐ School Personnel ☐ Student *
*** For asthma/severe allergy when a student is totally responsible to give medication without staff supervision or assistance, complete both sides of form.**

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

Student Giving Self Emergency Medication for Asthma and/or Severe Allergy
without Staff supervision or assistance (complete this side and Parent Request and Physicians order Form for Medication (Form 1702))

Student's Name _____ School _____

To be completed by physician:

The student must have the medication(s) listed on the reverse side during the school day or at school sponsored events in order to function at school. **Adult supervision is not needed.** The student has been instructed in the treatment plan, self-administration of the listed medication(s) and has demonstrated the skill level necessary to self-administer medications for:

☐ Asthma

☐ Severe Allergy

For Epinephrine Auto Injector only:

☐ In the event the student is experiencing respiratory difficulty and is unable to administer the Epinephrine Auto Injector the School Based Public Health Nurse will train designated school staff to administer the Epinephrine Auto Injector and call 911.

_____ _____

Printed Physician's Name Telephone

_____ _____

Signature Date

To be completed by parent:

I request and give permission for my child to carry and give the medication listed on the reverse side during the school day, at school-sponsored activities or while in transit to or from school. **Adult supervision is not needed.**

I understand that:

- I shall provide to the school back-up medication (in addition to what student will carry) that shall be kept at school.
- My child will be required to demonstrate the skill level necessary to use the self-administered medications to school staff trained by the school nurse.
- My child will be subject to disciplinary action if medication is used in any other manner than that prescribed.
- I have observed my child demonstrate the necessary skill level to implement the care plan prescribed by his/her health care provider.

☐ Asthma

☐ Severe Allergy

For Epinephrine Auto Injector only:

☐ In the event my child is experiencing respiratory difficulty and is unable to administer the Epinephrine Auto Injector ordered by the physician, a trained school staff member may administer the Epinephrine Auto Injector and call 911.

_____ _____

Parent Signature Date

FOR SCHOOL USE ONLY

To be completed by student at school:

- I have demonstrated the use of my medication to the school staff listed above.
- I plan to keep my medication and equipment with me at school.
- I will use only as prescribed by my doctor.
- I will not allow any other person to use my medication.
- I will notify a school staff member if I am having more difficulty than usual with my health condition.

_____ _____

Signature of Student Date

To be completed by trained designated school staff:

I have observed the student indicated above verbalize and demonstrate the skill level necessary to use the medication prescribed by the above physician.

** Attach checklist used for demonstration**

1. _____ _____

2. _____ _____

Signature of Designated school staff Date