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*

Approved by: _____ Signature of Principal _____ Date _____

Authorization for Student to Carry and Independently Self-Administer Emergency Medication for Asthma and/or Anaphylaxis (complete this side in addition to reverse side)

Student's Name _____ School _____

To be completed by physician:

Diagnosis: _____

The student indicated above 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. 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 and/or Anaphylaxis. The student will not require adult supervision.

For Epipen only:

☐ In the event the student is experiencing respiratory difficulty and is unable to administer the Epipen, a trained school staff member may administer the medication and call 911. I have discussed with the parent /guardian that the School Based Public Health Nurse will train designated school staff to administer the medication.

Telephone	Printed Physician's Name	Signature	Date

To be completed by parent:

I request and give permission for my child to carry and self-administer the medication as indicated in the physician's order during the school day, at school-sponsored activities or while in transit to or from school. I have observed my child demonstrate the necessary skill level to implement the care plan prescribed by his/her health care provider. Adult supervision will not be required.

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 in a location accessible to the student in the event of an emergency.
- My child will be required to demonstrate the skill level necessary to use self-administered medications to a school designee trained by the school nurse.
- My child will be subject to disciplinary action if medication is used in any other manner than that prescribed.

For Epipen only:

☐ In the event my child is experiencing respiratory difficulty and is unable to administer the Epipen, a trained school staff member may administer the medication and call 911. I give permission for the School Based Public Health Nurse to instruct designated staff to administer the medication in the event of an emergency if the student cannot. I understand that non-medical personnel will administer the medication.

Parent Signature _____ Date _____

FOR SCHOOL USE ONLY

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

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 _____