The Magellan Charter School

Phone# 919-844-0277 Fax # 919-844-3882

Parent Request and Physician's Order Form for Medication

To Be Completed By Parent:

Child's Name _____ Age_____ Homeroom Teacher_____

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:

- **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 after school activities/sports, I will assume responsibility for notifying the instructor/coach of my child's medical condition. I will contact the school nurse if assistance is needed in training the instructor/coach 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 and Magellan Charter School that is necessary in carrying out services for my child.**

_____ _____ _____

Parent/Guardian Signature Telephone Date

To Be Completed By Doctor:

The child indicated above must have the medication(s) listed below 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 _____

Side effects to watch for _____

Duration of Order _____

_____ _____ _____

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

_____

Telephone

To Be Completed By School:

Staff Training: _____

Name_____ Title_____