WAKE COUNTY
PUBLIC SCHOOL SYSTEM

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

Student Name: **DOB:** **School:** **School Year:**

	Diagnosis	Name of Medication (**Right** Medication)	Dosage (**Right** Amount)	How to give (**Right** Route)	Time(s) to Give (**Right** Time)	Medication Log Date/Staff Signature 1	2	3	4	5
Daily Medication(s)	☐ ADHD ☐ Cystic Fibrosis ☐ Seizure ☐ Diabetes ☐ Other: _____									
Emergency Medication(s)	Allergy Allergen: _____	☐ Diphenhydramine (Benadryl)	☐ 12.5 mg ☐ 25 mg ☐ other: _____	By Mouth	☐ Upon Exposure ☐ Mild Reaction					
		☐ Epinephrine Auto Injector	☐ 0.15 mg ☐ 0.3 mg	Intramuscular (IM)	☐ Upon Exposure ☐ Severe Reaction ☐ If provided, repeat dose after _____ min for continued symptoms.					
	Seizures	☐ Diastat Gel	☐ 5.0 mg ☐ 7.5 mg ☐ 10.0 mg ☐ _____ mg	Rectal	☐ At onset of seizure ☐ After 5 minutes ☐ After 10 minutes					
	Diabetes	☐ Glucagon	☐ 0.5 mg ☐ 1.0 mg	☐ Subcutaneous (SQ) ☐ Intramuscular (IM)	If student becomes unconscious					
Asthma	Exercise Induced Asthma	☐ Albuterol ☐ Xopenex	☐ 2 puffs ☐ 1 vial (ampule)	☐ Inhaler with spacer, if provided ☐ Nebulizer	Before exercise/as needed to prevent symptoms					
	Asthma Yellow Zone	☐ Albuterol ☐ Xopenex	**Please check one** ☐ 2 puffs ☐ 4 puffs ☐ 1 vial (ampule)	☐ Inhaler with spacer, if provided ☐ Nebulizer	☐ Every 4 hours/as needed to relieve symptoms ☐ _____					
	Asthma Red Zone		**Call 911** ☐ 4 puffs ☐ 1 vial (ampule)	☐ Inhaler with spacer, if provided ☐ Nebulizer	**For Emergency Symptoms**					
As Needed PRN Meds										

MD Stamp below

Physician Printed Name: _____ **Date:** _____ **Telephone:** _____

Physician Signature: _____ _____ **Fax:** _____

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Student Name: **DOB:** **School:** **School Year:**

To be completed by parent:

I understand that:

- Non-medical personnel conduct the medication administration.
- It is my responsibility to have an adult transport the medication to school.
- If medication is not available at the school, 911 will be called for emergencies.
- 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. 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 of if a copy of the information needs to be shared with them.

I request that:

- My child be administered the medication as indicated in the physician's order.
- If an emergency injection is ordered, I give permission for the school nurse to instruct designated staff in the administration technique.

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.

I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed physician.

I hereby release the Board of Education and their agents and employees from any and all liability that may result form my child taking the prescribed medication.

Parent/Guardian Signature: _____ **Phone:** _____ **Phone :** _____

Student Self-Carry and Self-Administration of Emergency Medication

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 for the listed medication(s) and has demonstrated the skill level necessary to self-administer medications for:

☐ Asthma ☐ Allergy ☐ Insulin Other: _____

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 nurse will train designated school staff to administer the Epinephrine Auto Injector and call 911.

Printed Physician's Name: _____

Physician's Signature: _____ **Date:** _____

To be completed by student at school:

☐ I have demonstrated the use of my medication to the school staff listed.
☐ 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.

Student 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 too or from school. **Adult supervision is not needed.**

I understand that:

- I shall provide 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 medication 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 prescribed.

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.

I have observed my child demonstrate the necessary skill level to implement the care plan prescribed by his/her health care provider.

Parent Signature: **Date:**

To be completed by school nurse:

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

☐ Epinephrine Auto Injector ☐ Inhaler

Nurse Signature: _____ **Date:** _____

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