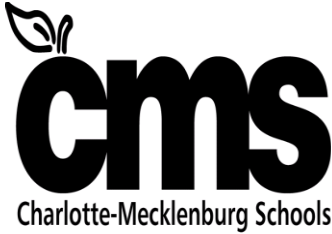

Mecklenburg County Health Dept

SCHOOL HEALTH SERVICES
A Partnership for Serving Children

Order for treatment or procedure: ____

Student's Name: ____________________________________ DOB: ______________________
Student's Address: ____
Student's Phone #: __________________________ Student's I.D: _________________________
Mother's Name: __________________ Phone: Work _______________Cell _______________
Father's Name: ___________________ Phone: Work _______________Cell _______________
Preferred Hospital: ____
School: ______________________________ Teacher/Grade/Homeroom: __________________

Student's Diagnosis: ____

Health Care Provider's Order/Instructions:

____

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Duration of order: School Year ____________________

Health Care Provider________________________ Phone # __________FAX #_____________
Address:____
Signature_____________________________________Date_____________________________
(Please sign here to authorize this order and return to the School Health Program, MCHD, 3205 Freedom Drive, Suite 8500-Building K Charlotte, N.C. 28202 Fax: 704-432-2079 Attn: School Health.)

I have reviewed this order on and give my permission for the School Health Nurse to train school personnel to follow this order.
Parent Signature____ Date_______________

I have provided training and instruction regarding this order to: ___________________________

____

School Health Nurse Signature _____________________________ Date________________