



Parent Request and Physician's Order form for Medication

To be completed by PARENT:

Child's Name: _____ **Age:** _____

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 medical staff of Endeavor Charter School to instruct designated staff in the administration technique. I understand that it is my responsibility to transport the medication to school and to make school personnel aware of the need to transport medication on extended field trips away from Endeavor.

I understand that:

- (1) No employees and agents of Endeavor Charter School shall be liable in civil damages to any party for any act authorized or for any omissions relating to that act, unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing.
- (2) Information shared may be in the form of an emergency/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.
- (3) 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 specific assistance for him/her.
- (4) 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 activating emergency services (911).
- (5) I assume responsibility for notifying my child's teacher of my child's medical condition. I may request instruction by members of the medical committee of the Endeavor Board of Directors in a medical procedure or technique.

I authorize: The release and exchange of medical information between my child's physician and any representative of Endeavor Charter School that is necessary in carrying out services for my child.

Parent/Guardian Signature

Date

Emergency Contact # 1

Emergency Contact #2

To be completed by PHYSICIAN:

Name and Form of Medication

Dosage and time to be given

Symptoms to be given for

Route of administration

Administration by: School Personnel Student (please complete the student carry and self-administer form)

Significant Side Effects

Duration of Order

Physician's Name (please print)

Physician's Signature

Physician's Telephone

Date

To be completed by SCHOOL:

I am aware of the above student's medication requirements as noted above and will administer the medication as directed.

Endeavor Staff Signature
