



SCHOOL HEALTH SERVICES
A Partnership for Serving Children

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: _____

9. Other:

(Please sign here to authorize this order and return to the School Health Program, MCHD 3205 Freedom Drive Suite 8500, Charlotte, N.C. 28208 – Please fax completed form to the School Nurse

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

Parent /Guardian Signature_____ **Date**_____

I have provided training and instruction regarding this order to: _____
(Signatures of personnel trained)

_____, _____

School Health Nurse Signature

Date