Charlotte-Mecklenburg Schools

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:

_____

_____

_____

_____

_____

_____

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, Hal Marshal Annex, 618 North College Street, 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_____