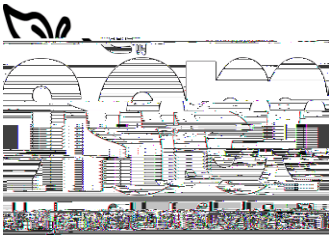

Mecklenburg County Health Dept

SCHOOL HEALTH SERVICES
A Partnership for Serving Children

Order for treatment or procedure: _____

St

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_____