

MARYLAND STATE SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year 2017-2018 including the summer session.

School: St. Maria Goretti High School, 1535 Oak Hill Ave., Hagerstown, MD 21742, Ph: 301-739-4266, Fax: 301-739-4261

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

- * Prescription medication must be in a container labeled by the pharmacist or prescriber.
* Non-prescription medication must be in the original container with the label intact.
* An adult must bring the medication to the school.
* The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Name of Student: Date of Birth: Grade:

Condition for which medication is being administered:

Medication Name: Dose: Route:

Time/frequency of administration: If PRN, frequency:

If PRN, for what symptoms:

Relevant side effects: None expected Specify:

Medication shall be administered from: to Month / Day / Year Month / Day / Year

Prescriber's Name/Title: (Type or print)

Telephone: FAX:

Address:

Prescriber's Signature: Date:

(Original signature or signature stamp ONLY)



(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): for the above medication on (Date):

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: Date:

Home Phone #: Cell Phone #: Work Phone #:

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of emergency medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: Signature Date

School RN approval for self carry/self administration of emergency medication: Signature Date

Order reviewed by the school RN: Signature: Date: