MARYLAND STATE
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current) ___________________ including the summer session.

School: ____________________________________________________________

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 __________

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