

PLEASE DO NOT WRITE ABOVE THIS LINE - FOR MAGNUS HEALTH USE ONLY



PRESCRIPTION MEDICATION FORM

This coversheet is **ONLY** for the form and student listed above
and **MUST BE RECEIVED** for processing.



DO NOT use staples or paperclips!



Please print and complete this form then
submit all pages including this coversheet via:

FAX	MAIL
<p>(877) 447-9530</p> <p>Outside of the United States? Please fax to (978) 244-8894</p>	<p>-OR-</p> <p>Magnus Health Does Not Accept Mailed Forms</p>

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