ST. MARY'S COUNTY PUBLIC SCHOOLS

Department of Student Services/St. Mary's County Health Department

PARENT(S)/LEGAL GUARDIAN(S) AND PHYSICIAN/PRESCRIBER AUTHORIZATION - MEDICATION ORDERS

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

Name of Student: _____ Date of Birth: _____ Grade: _____ 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, type, time, and route 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

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: _____

Duration of Administration: _____

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): _____.

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

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 administration policy.

_____ It has been determined this student is able to self-administer and carry emergency medication and has been trained in its use.
Prescriber's Initials

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

Note: A non-nursing person may administer medication(s). If possible, arrange time of dosage so that medication(s) will not have to be given while the child is in school. School hours vary with each school.

Parent(s)/Legal Guardian(s) Authorization/Approval

I/We request designated school personnel to administer the medication as prescribed by the 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 it is my/our responsibility to furnish this medication. I/We further understand that any school employee who administers any drug to my/our child, in accordance with written instructions from the prescriber and St. Mary's County Public Schools, shall not be liable for damages as a result of an adverse drug reaction suffered by my/our child due to the administration of the drug. 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(s)'/Legal Guardian(s)' Signature: _____ Date: _____

Note: When this form is complete and signed by the physician and parent(s)/legal guardian(s), return it to the school nurse at your child's school along with the prescribed medication in the original pharmacy container. Thank you.

Order reviewed by the school RN: _____
Signature **Date**