CARROLL COUNTY PUBLIC SCHOOLS MEDICATION FORM

Name: _____ D.O.B.: _____ Allergies: _____Grade/Teacher: _____Bus #_____

Medication:_____ Route: _____ Strength: _____ Dosage: _____ Time: _____**Expiration date**: _____

Order valid for current year including summer school or until (date):_____ Reason: _____ Side Effects:_____

Instructions for early dismissals or delayed mornings:_____

If medication administration is necessary during school hours, this form must be completed before any representative of the school can administer prescription or non-prescription medications to your child. **Special Notes:**

1. **Prescription Medications must be in original container marked specifically for student, labeled by pharmacist or prescriber. Over the counter medications must be in the original unopened container with the manufacturer's label intact.**
2. **All homeopathic/herbal prescription AND non-prescription medicines require a parent AND authorized prescriber signature. In Maryland, an authorized prescriber is a physician, nurse practitioner, certified midwife, podiatrist, and physician assistant or dentist.**
3. **Medications are not to be transported by students. This is in violation of our Drug-Alcohol policy. Medication shall be returned to the parent/ responsible adult when the order or the medication has expired. Nurse should notify parent/guardian of medication which expires during the school year. Expired medication not collected by parent/guardian or designated responsible adult will be discarded within 7 calendar days. All medications not claimed at the end of the school year will be destroyed.**

*** (Maryland law allows prescription medication to be used only for 1 year beyond date of issue or expiration date indicated on the medication – whichever comes first.)**

Authorized Prescriber Name (Please Print)_____ **Authorized Prescriber Signature:**_____ **Date:**_____

Authorized Prescriber Phone #_____

Parent/Guardian Signature:_____ **Date:**_____

Emergency Medication Release: (It is the student's responsibility to report usage to the school nurse). Expiration date of self-carry emergency medication: ____

This section must be completed in addition to the above for those students who request permission to carry their own emergency medication.
We acknowledge that the student named above has been instructed as to the proper use, understands the purpose and the appropriate method as well as the frequency of use of their emergency medication. We request that the student may be able to self-carry their emergency medication on their person and understand that the emergency medication not be left in student locker or desk.

Parent/Guardian Signature:_____ **Authorized Prescriber Signature:**_____

Date:_____ **Date:**_____

Codes (chart reason)

			Initial	**Name**	**Initial**	**Name**
A – Absent	F – Field Trip	N – Non-Available	_____	_____	_____	_____
C – School Closed	H – Holiday	R – Refused	_____	_____	_____	_____
E – Early Dismissal	L – Late Opening	W – Dose Withheld	_____	_____	_____	_____

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
August																															
September																															
October																															
November																															
December																															
January																															
February																															
March																															
April																															
May																															
June																															
July																															

Nursing Notes:_____

MEDICATION COUNT

DATE	MEDICATION	DOSE	TOTAL REC'D	NURSE INITIAL	PARENT SIGNATURE

NURSING NOTES

DATE	COMMENTS

Initial: _____ Name: _____

Initial: _____ Name: _____

Initial: _____ Name: _____

Initial: _____ Name: _____

Initial: _____ Name: _____

Initial: _____ Name: _____