ST. MARY'S COUNTY PUBLIC SCHOOLS

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

PARENTS/LEGAL GUARDIANS AND PHYSICIAN/PRESCRIBER AUTHORIZATION – MEDICAL PROCEDURES

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 medical procedure/treatment. A new medical procedure form must be completed at the beginning of each school year for each treatment, and each time there is a change in dosage, type, and route administration.

- Medical equipment must be provided by the parents/legal guardians.
- An adult must bring the medical equipment 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 medical procedure/treatment.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for Which Medical Treatment is Being Administered: _____

Medical Procedure: _____
(Give detailed instructions or attach a standard protocol to be followed at school).

Medication Name: _____ Dose: _____ Route: _____

Time/Frequency of Administration: _____ If PRN, Frequency: _____

If PRN, for What Symptoms: _____

Equipment Needed: _____

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 medical procedure on (Date): _____.

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

Order Reviewed by the School RN: _____
Signature Date

******This section to be completed by the parents/legal guardians.******

Name of Student: _____

I/We request designated school personnel to administer the medical procedure/treatment as prescribed by the prescriber. I/We certify that I/we have legal authority to consent to a medical procedure for the student named above, including the administration of a medical treatment at school.

I/We understand that it is my/our responsibility to furnish all information and equipment required to administer this procedure at school.

I/We further understand that any school employee who administers the medical procedure 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 medical equipment, otherwise it will be discarded.

I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parents/Legal Guardians Signature: _____

Date: _____