

**ST. MARY'S COUNTY PUBLIC SCHOOLS**

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

**PARENTS/LEGAL GUARDIANS AND PHYSICIAN/PRESCRIBER AUTHORIZATION – MEDICATION ORDERS**

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, 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

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: \_\_\_\_\_

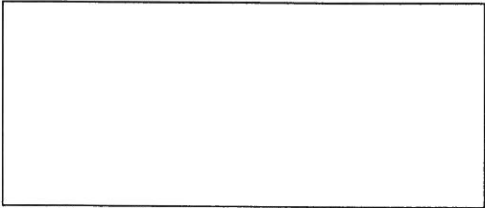
Relevant Side Effects:  None Expected  Specify: \_\_\_\_\_

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 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

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.

PARENTS/LEGAL GUARDIANS AND PHYSICIAN/PRESCRIBER AUTHORIZATION – MEDICATION ORDERS  
(CONTINUED)

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

Name of Student: \_\_\_\_\_

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.

Parents/Legal Guardians Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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