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

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

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