**MARYLAND STATE**

M.D. & Parent

**SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM**

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

**School: The Maryland School for the Blind**

**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 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 maybe 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**

**2004**