MARYLAND STATE

SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current) 2025-2026 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 medication.

* Prescription and over-the-counter medication must be in a container labeled by the pharmacist and must match.
* All prescription and over-the-counter medication must have a physician order and be in a container labeled by the pharmacist.
* An adult must bring the medication to the school or mail them to the school by the due date.
* All medications must be received by the Health Center by August 18, 2025. They may be delivered by the parent in person or mailed.

# Prescriber's Authorization

Name of Student: Click or tap here to enter text.

Date of Birth: Click or tap to enter a date.

Grade: Click or tap here to enter text.

Condition for which medication is being administered: Click or tap here to enter text.

Medication Name: Click or tap here to enter text.

Dose: Click or tap here to enter text.

Route: Click or tap here to enter text.

Time/frequency of administration: Click or tap here to enter text.

If PRN, frequency: Click or tap here to enter text.

If PRN, for what symptoms: Click or tap here to enter text.

Relevant side effects: [ ]  None expected [ ]  Specify: Click or tap here to enter text.

Medication shall be administered from Click or tap to enter a date. to Click or tap to enter a date.

Prescriber’s Name/Title: Click or tap here to enter text.

Telephone: Click or tap here to enter text.

FAX: Click or tap here to enter text.

Address: Click or tap here to enter text.

Prescriber's Signature (Original signature or **signature** stamp only): Click or tap here to enter text.

Date: Click or tap to enter a date.

Use the box below for Prescriber's Address Stamp:

A verbal order was taken by the school RN (Name): Click or tap here to enter text. for the above medication on (Date): Click or tap to enter a date.

# PARENT/GUARDIAN AUTHORITZATION

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 the 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: Click or tap to enter a date.

Home Phone #: Click or tap here to enter text.

Cell Phone #: Click or tap here to enter text.

Work Phone #: Click or tap here to enter text.

# 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 authorization for self carry/self administration of emergency medication:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Click or tap to enter a date.

School RN approval for self carry/self administration of emergency medication:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Click or tap to enter a date.

Order reviewed by the school RN:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Click or tap to enter a date.

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