MARYLAND STATE
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

M.D. & Parent

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 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 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 24, 2026. They may be delivered by the parent in person or mailed.**

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)

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**

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