

**FREDERICK COUNTY PUBLIC SCHOOLS/FREDERICK COUNTY HEALTH DEPARTMENT**

**MEDICATION AUTHORIZATION FORM**

**This order is valid only for the current school year \_\_\_\_\_ (Including Summer Session)**

**OR**

**Start Date: \_\_\_/\_\_\_/\_\_\_ to Stop Date: \_\_\_/\_\_\_/\_\_\_**

***This medication form must be completed fully in order for staff to administer 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 provider.
- Over-the-counter medication must be in the **original unopened container** with the label intact.
- Students are prohibited from transporting medications.
- The provider will be called if a question arises about the student and their medication.
- Thoroughly review reverse side of form before completion.

**HEALTH CARE PROVIDER AUTHORIZATION**

Name of Student:		Date of Birth:
Allergies:		Grade:
Condition for which medication is being administered:		
Medication Name:	Dose:	Route:
Time of Administration:	If PRN, frequency:	
Additional Instructions:		
Relevant side effects: <input type="checkbox"/> None expected <input type="checkbox"/> Specify:		
Specific Instructions for Inhalers: Symptoms for Inhaler administration: <input type="checkbox"/> Coughing <input type="checkbox"/> Audible wheezing <input type="checkbox"/> Complaint of tightness in chest <input type="checkbox"/> Complaint of shortness of breath <input type="checkbox"/> Other _____		
Health Care Provider's authorization for student to: Self-carry: <input type="checkbox"/> Yes <input type="checkbox"/> No    Self-administration: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Health Care Provider's name/title: (type or print)		
Telephone:	Fax:	Use for Health Care Provider's Address Stamp
Address:		
Health Care Provider's Signature:	Date:	

**PARENT/GUARDIAN AUTHORIZATION**

I request designated staff to administer the medication as prescribed by the health care provider above. I certify that I have legal authority to consent to the administration of medication at school. I understand that at the end of the school year that the medication must be picked up by an adult or it will be destroyed.

Parent/Guardian Signature:	Date:
Parent/Guardian Phone:	Work Phone:

**REGISTERED NURSE AUTHORIZATION**

School registered nurse approval for student to: Self-carry:  Yes     No    Self-administration:  Yes     No

Signature:	Date:
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