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: ☐ None expected ☐ Specify:

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:

INHALER SELF-CARRY/SELF-ADMINISTRATION AUTHORIZATION/APPROVAL

Self-carry and/or self-administration of an inhaler may be authorized by the health care provider and must be approved by the school registered nurse.

Health care provider's authorization for: Self-carry: ☐Yes ☐ No Self-administration: ☐Yes ☐ No	Signature:	Date:
School registered nurse approval for: Self-carry: ☐Yes ☐ No Self-administration: ☐Yes ☐ No	Signature:	Date:
Order reviewed and signed by school registered nurse:		Date: