

SAINT MARGARET SCHOOL/MIDDLE SCHOOL & EXTENDED DAY CARE  
MEDICATION ADMINISTRATION AUTHORIZATION FORM

Elementary School Campus  
205 Hickory Avenue  
Bel Air, MD 21014  
Phone: 410-879-1113  
410-838-8713  
FAX: 410-838-5879



Middle School Campus  
1716 A Churchville Road  
Bel Air, MD 21015  
Phone: 410-877-9660  
410-420-9320  
FAX: 410-420-9322

**THIS ORDER IS VALID ONLY FOR SCHOOL YEAR \_\_\_\_\_ (CURRENT)**

This form must be completed in full in order for Saint Margaret's personnel to administer the required medication. A new medication administration form must be completed 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
  - ❖ On late openings or dismissed early days, medication will be given at regularly scheduled times unless other arrangements are made.
- Medication scheduled to be given during the lunch hour is not given on early dismissal days unless arrangements are made with the school to give it.

**PRESCRIBER'S AUTHORIZATION:**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Condition for which medication is being administered: \_\_\_\_\_

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Time/frequency of administration: \_\_\_\_\_ If PRN, frequency: \_\_\_\_\_

If PRN, for what symptoms: \_\_\_\_\_

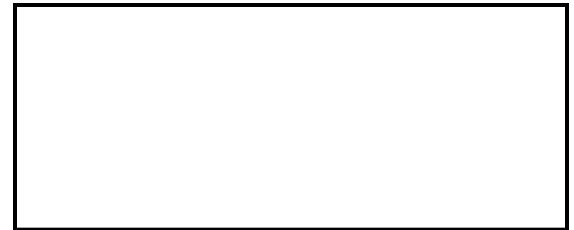
Relevant side effects:  None expected  Specify: \_\_\_\_\_

Medication shall be administered from: \_\_\_\_\_ to \_\_\_\_\_  
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: \_\_\_\_\_  
(Type or Print)

Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_



(Use for Prescriber's Address Stamp)

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Original signature or signature stamp ONLY)

Verbal Order: In certain instances a verbal order may be taken from a doctor, but this must be followed by a signed order within 5 school days.

A verbal order was taken by the school RN (Name) \_\_\_\_\_ for the above medication on (Date): \_\_\_\_\_

Parent/guardian/caretaker authorization:

I/We request the school personnel or extended day 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 names 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. With this permission, I release Saint Margaret School/Extended Day Care and its designee from any responsibility regarding administration of designated medication.

Parent/Guardian/Caretaker Signature \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

**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'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 \_\_\_\_\_