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