

ANNE ARUNDEL COUNTY
SCHOOL HEALTH SERVICES PROGRAM

PARENT'S REQUEST TO ADMINISTER MEDICATION AT SCHOOL

FOR COMPLETION BY PARENT/GUARDIAN

Name of Student: _____ D.O.B: ____/____/____
(LAST) (FIRST) (MI)

Name of School: _____ Grade: _____ School Year: _____

In order for my child to receive medication in school, I agree to the following:

- All prescription and non-prescription medication will have a physician's signed order **fully** completed for each school year.
- The prescription medication will be in a container labeled by the pharmacist or physician with:
 - *Name of child.* *Name of the medication.* *Dosage, route and time of administration.*
 - *Name of physician.* *Prescription date and expiration date.* *Conditions for proper storage.*
- The non-prescription medication will be in the original sealed container with the label intact. Student's name will be put on the container in a position that does not obscure the label.
- The medication will be brought to school by an adult.
- The physician will be called if a question arises about my child's medication.
- The first dose of this medication (except for epinephrine auto-injector) has been given without problems.

Having read the above conditions, I request Anne Arundel County School Health Services personnel administer the medication as prescribed by the physician below. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school.

 **Signature of Parent/Guardian:** _____ **Date:** _____

Relationship to student _____

Phone Number: (H) _____ (W) _____ Other _____

Address: _____

**PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL
ONE MEDICATION PER FORM**

Diagnosis: _____

Name of Medication: _____

Dosage: _____ (mg, ml, ml/tsp, # of puffs)

Route: _____ Time of Administration at School: _____ Lunchtime

If PRN, for what symptoms? _____ How Often? _____

Please list any specific precautions personnel should be aware of or any unusual effects that might be observed.

Student medication allergies: None Known _____

Services from the beginning to the end of school year **OR**

Services should begin (Date) _____ and terminate (Date) _____ .

FOR INHALER, EPINEPHRINE AUTO-INJECTOR, AND INSULIN ONLY:

_____ It has been determined that this student is able to self-administer and carry inhalant medication or epinephrine auto-injector and has been trained in its use, including knowing when the medication is to be used.

_____ It has been determined that this student is able to self-administer insulin.

_____ This student should not self-administer inhalant medication, insulin, or epinephrine auto-injector.

 **Physician's Signature:** _____ **Date:** _____

Original signature/NO stamps

Physician's Name (Printed): _____

Address: _____

Telephone Number: _____

Order and MAR Reviewed _____ R.N. Date _____