

MARYLAND STATE SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM



This order is valid for one	year from the date of	f prescriber's signature below	•
School:			
This form must be completed fully in order for school administration form must be completed annually, for administration of a medication.			
* Prescription medication must be in a container labeled * Non-prescription medication must be in the original con * An adult must bring the medication to the school. * The school nurse (RN) will call the prescriber, as allowed	tainer with the label in	tact.	r the child's medicatior
<u>Pre</u>	scriber's Authorizatio	<u>on</u>	
Name of Student:	Date of Birth: _		_ Grade:
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: Month / Day / Year		_to	
		Month / Day / Year	
Prescriber's Name/Title:(Type or print)			
Telephone:FAX:			
Address:			
Prescriber's Signature: [Original signature or signature]	oate:	(Use for Prescriber's Ad	Idraes Stamp)
A verbal order was taken by the school RN (Name):		•	.,
A verbal order was taken by the school Kit (Maine).		for the above medication on	(Date)
I/We request designated school personnel to administer have legal authority to consent to medical treatment for school. I/We understand that at the end of the school yel/We authorize the school nurse to communicate with the	the student named abo ear, an adult must pick	scribed by the above prescriber. ove, including the administration up the medication, otherwise it	of medication at
arent/Guardian Signature:		Date:	
Home Phone #: Cell Phone #	t:	Work Phone #:	
SELF CARRY/SELF ADMINISTRATION O Self carry/self administration of emergency medication r nurse according to the State medication policy.			-
Prescriber's authorization for self carry/self administration	n of emergency medica	ation: Signature	 Date
School RN approval for self carry/self administration of e	mergency medication:		Date Date
		Signature	Dale

Signature

Date

Order reviewed by the school RN: __