MERCY HIGH SCHOOL
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM
(Adapted from Maryland State Department of Education Form)

This order is valid only for school year 2018-2019.

This form must be completed in full in order for the school to administer any required medication. A new 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 during the school year.

1. Prescription medication must be in a container labeled by the pharmacist or prescriber.
2. Non-prescription medication must be in the original container with the label intact.
3. An adult must bring the medication to the school.
4. If a question arises about the student's medication, the school's Case Manager/Delegating Nurse will call the prescriber, as allowed by HIPPA.

Prescriber's Authorization

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: __________________________________ to ____
Month/Day/Year Month/Day/Year

Prescriber's Name/Title: ____ (This space for prescriber's address stamp)
(Type or print.)
Telephone:________________________ FAX: __________________________

Address: ____

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Prescriber's Signature: ____ Date: _____________________________________
(Original signature or signature stamp ONLY)

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medication treatment for the student named 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 Case Manager/Delegating Nurse to communicate with the health care provider as allowed by HIPPA.

Parent/Guardian 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 Case Manager/Delegating Nurse according to the State medication policy.

Prescriber's authorization: Signature: ____ Date: _____________________

School Delegating Nurse approval: Signature: ____ Date: _____________________

ORDER REVIEWED BY MHS DELEGATING NURSE: ____________________________________ Date: ______________________